

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, California 95814

April 26th, 2007

ALL COUNTY INFORMATION NOTICE NO. I-21-07

TO: ALL COUNTY WELFARE DIRECTORS
ALL CALWORKS PROGRAM SPECIALISTS
ALL COUNTY FOOD STAMP COORDINATORS
ALL COUNTY CONSORTIUM PROJECT MANAGERS
ALL WELFARE TO WORK COORDINATORS

REASON FOR THIS TRANSMITTAL

☒ State Law Change
☐ Federal Law or Regulation Change
☐ Court Order
☒ Clarification Requested by One or More Counties
☒ Initiated by CDSS

SUBJECT: CalWORKs: Forms Changes Due To Changes in Homeless Assistance, Food Stamp Utility Allowance Deductions, Racial and Ethnic Data Collection, and Welfare to Work Sanctions.

REFERENCE: Federal Register, Vol.71, No.96, May 18, 2007; Assembly Bill (AB) 1808 (Ch.75 Statutes of 2006) and All County Letter (ACL) 06-14, ACL 06-25, ACL 06-31, and All County Information Notice I-40-06

A variety of changes were made to several forms as a result of CalWORKs and Food Stamps policy changes, and at the request of the California Welfare Director's Association, County Advisory Team, and advocates.

REVISED FORMS

CW 2166 (11/06) – Work Pays Notice

QR 22 (12/06) – Sponsored Noncitizens Applying For or Receiving Cash Aid and/Or Food Stamps

QR 72 (12/06) – Sponsor's Quarterly Income and Resource Report

SAWS 1 (12/06) – Application for Cash Aid, Food Stamps, AND/OR Medi-Cal/34 County Medical Services Program; includes coversheet.

SAWS 2 (01/07)–Statement of Facts for Cash Aid, Food Stamps, and Medi-Cal/34-County Medical Services Program

SAWS 2A QR (01/07) – Rights and Responsibilities and Other Important Information

SUMMARY OF REVISIONS**QR 22, QR 72, and CW 2166**

The budget/income calculations were revised and updated in these forms.

SAWS 1

- Homeless Assistance changes due to AB 1808 statutory requirements on Coversheet under "Cash Aid and Homeless Assistance".
- Included Ethnic Data pursuant to Federal Requirements in item 10 of the form.

SAWS 2

- Added the Food Stamp Standard Utility Allowance (SUA), the Limited Utility Allowance (LUA), and the Telephone Utility Allowance (TUA) deductions under County Use Area on Page 10. These changes are due to Federal and State requirements.
- Changed Child age from 6-16 to 6-18 on Page 4, bullet 16 to be consistent with the QR7 form.

SAWS 2A QR

- Added the Food Stamp SUA, LUA, and TUA deductions on page 8, under "Food Stamps Only" section.
- Added "to prevent eviction" on Page 5 of the form under "Homeless Assistance" due to AB 1808 homeless assistance requirements.
- Added Welfare to Work changes under "Sanctions for Not Meeting Cash Aid Work Rules" due to sanction requirements per AB 1808.

CAMERA-READY COPIES AND TRANSLATIONS

For a camera ready copy of English, contact the Forms Management Unit at (916) 657-1907. If your office has internet access, you may obtain these forms from the CDSS web page at: http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm.

When all translations are completed per Manual of Policies and Procedures Section 21-115.2, including Spanish forms, they are posted on an ongoing basis on our web site. Copies of the translated forms and publications can be obtained at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_274.htm. For questions on translated materials, please contact Language Services at (916) 651-8876.

Please use existing stock on all forms except for the SAWS 1 and the SAWS 2A QR. The revised SAWS 1 and the SAWS 2A QR should be used immediately upon availability from the warehouse.

If you have CalWORKs questions pertaining to these forms, please contact Linda Lattimore, CalWORKs Eligibility Bureau, at (916) 654-2116 or e-mail at Linda.lattimore@dss.ca.gov. If you have Employment related questions, please contact Ryan Fruchtenicht, Employment Bureau, at (916) 651-9958 or e-mail at Ryan.Fruchtenicht@dss.ca.gov. If you have Food Stamps related questions, please contact Fred Hodges, Food Stamp Bureau, at (916) 653-7973 or e-mail at Frederick.Hodgesiii@dss.ca.gov.

Sincerely,

Kären Dickerson, Chief
Employment and Eligibility Branch

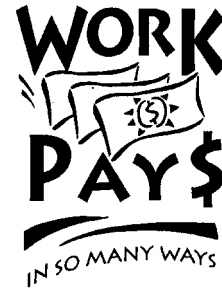
Attachments

c: CWDA
CSAC

WORK REALLY PAYS! HERE'S HOW:

You can work and still get CalWORKs cash aid as long as you remain eligible. When you add the amount of your earnings to your cash aid, you will have more \$\$\$ for your family. Work also:

- Builds a better life for you and your family.
- Builds your self-esteem.
- Develops your job skills, and helps you get a better job.
- Gives you personal satisfaction.

**HERE IS AN EXAMPLE OF HOW WORK PAYS FOR MARY AND HER TWO CHILDREN (REGION 2):****Step 1 We figure Mary's weekly gross earnings:**

\$6.75 x 32 hours = \$216 Weekly Earnings

Step 2 We figure Mary's monthly gross earnings:

\$216 x 4.33 weeks = \$935.28 Monthly Gross Earnings

Step 3 We figure Mary's monthly countable earnings:

Mary's Monthly Gross Earnings	\$	935.28
Less \$225 deduction	-	225.00
Balance	\$	710.28
Less 50% (half) deduction (\$710.28 ÷ 2 = \$355.14)	-	355.14
Equals Countable Earnings	\$	355.00*

Step 4 We figure Mary's cash grant:

Non-exempt Maximum Aid	
Payment (MAP) for 3 (Region 2)	\$ 689.00
Less Mary's Countable Earnings	- 355.00 *
Equals Cash Grant	\$ 334.00

Step 5 We figure Mary's total monthly income:

Monthly Gross Earnings	\$	935.00*
Plus Cash Grant	+	334.00
Equals Total Gross Income	\$	1,269.00

FIGURE YOUR EARNINGS AND CASH AID:**Step 1 Figure your weekly gross earnings:**

Your hourly wage \$ _____ x your weekly hours of work _____ = your Weekly Gross Earnings \$ _____.

Step 2 Figure your monthly gross earnings:

Your Weekly Gross Earnings \$ _____ x 4.33 weeks = your Monthly Gross Earnings \$ _____.

Step 3 Figure your monthly countable earnings:

Your Monthly Gross Earnings (from Step 2)	\$	<input type="text"/>
Less \$225 deduction	-	225.00
Balance	\$	<input type="text"/>
Less 50% (half) of balance	-	<input type="text"/>
Equals Countable Earnings	\$	<input type="text"/>

Step 4 Figure your cash grant:

Non-exempt Maximum Aid	
Payment (MAP) for a family your size	\$ <input type="text"/>
Less your Countable Earnings (from step 3)	- <input type="text"/>
Equals Cash Grant	\$ <input type="text"/>

Step 5 Figure your total monthly income:

Monthly Gross Earnings (from step 2)	\$	<input type="text"/>
Plus Cash Grant (from step 4)	+	<input type="text"/>
Equals Total Gross Income	\$	<input type="text"/>

* Countable income is rounded down to whole dollar amounts.

- For a translation of this notice, ask your worker.

若需本通知的翻譯本，請和你的工作人員聯絡。

(Chinese)

Si no puede leer este documento, pídale ayuda a su trabajador.

(Spanish)

Для перевода этого извещения обратитесь к работнику.

(Russian)

Để có bản dịch của thông báo này, xin liên lạc với nhân viên phụ trách hồ sơ của quý vị.

(Vietnamese)

TURN PAGE OVER FOR FACTS ABOUT OTHER BENEFITS YOU CAN GET FROM WORKING

WORK PAYS IN SO MANY OTHER WAYS, TOO!

SUPPORTIVE SERVICES

While in CalWORKs, you and the county will agree on certain goals and program activities to help you get a job and support your family without cash aid. To help you take part in these program activities, the county will provide supportive services for transportation, child care, ancillary costs, and counseling services to help with the transition to work.

CHILD CARE

You may have part or all of your child care paid. You can get paid child care while you look for a job, work, or take part in other approved CalWORKs activities, such as training or county orientation meetings. Your child care will be paid to the eligible child care provider that you choose.

If you are working or taking part in a county approved activity, you can get paid child care for the entire time you are on cash aid. After you go off cash aid, you can continue to get child care for up to 24 months.

After you have received 24 months of child care, you may continue to get child care if funding is available and your family remains eligible. The county or the local Alternative Payment Program agency will help you to find additional services.

JOB RETENTION SERVICES

Some counties provide job retention services for eligible former recipients as part of the CalWORKs program. Job retention services can be case management or other services that help you keep a job or get a better job. Ask your worker what services may be available in your county. Months you get job retention services do not count against the California 60-month time limit, and do not count against the Federal limit as long as you are employed.

You may get job retention services IF:

- You received a CalWORKs cash grant AND
- You went off cash aid because you got a job.

You can get these services for up to 24 months from the time you stopped getting a CalWORKs cash grant because of earnings from a job.

HEALTH COVERAGE IS IMPORTANT FOR YOU AND YOUR FAMILY

Your health coverage may continue when your CalWORKs cash aid stops.

- Depending on the reason your cash aid stops, you and your child(ren) may be eligible for continued no-cost or low-cost health coverage under the Medi-Cal or Healthy Families programs.

EARNED INCOME TAX CREDIT (EITC)

When you work and have low income, you can usually get the EITC. You must file a federal tax return to get the EITC. The money you get from the EITC will not lower your cash aid grant. If you would like to know more about the EITC, ask your employer or contact the Internal Revenue Service (IRS).

WORKING HELPS YOU AVOID THE TIME LIMITS ON CalWORKs CASH AID

State 18 and 24-Month Time Limits

To keep getting cash aid beyond 18 or 24 months, a parent or caretaker relative must work and/or take part in community service for the number of hours the county requires.

- The 18-month limit applies to recipients who began getting cash aid in or after the month the county started its CalWORKs Welfare-to-Work program. The county may extend the 18-month limit for an additional 6 months.
- The 24-month limit applies to recipients who began getting cash aid in the month before the county started its Welfare-to-Work program.
- The 18-month or 24-month time limit period starts when you and the county sign your Welfare-to-Work plan, or when you refuse to sign your Welfare-to-Work plan.

Federal and State 60-Month Time limits

As of January 1, 1998, a parent or caretaker relative can only get CalWORKs cash aid for up to a lifetime total of 60 months. Cash aid received from CalWORKs and/or from any other state counts toward the 60-month limit.

- There are exceptions to the 60-month time limit rule. These exceptions allow aid to continue past the time limit, or stop a month of aid from counting toward the time limit. Some of these exceptions are:
 - The limit does not apply to children.
 - A month on cash aid does not count toward the 60-month time limit when the person is:
 - ✓ Age 60 or older.
 - ✓ Exempt from taking part in Welfare-to-work activities for certain reasons.
 - ✓ Disabled for 30 days or more.
 - ✓ And other reasons your worker can tell you.
- Other states may have different rules for the 60-month time limit.

SPONSORED NONCITIZENS APPLYING FOR OR RECEIVING CASH AID AND/OR FOOD STAMPS

Important Information For Noncitizens Sponsored By Individuals

As a noncitizen who is sponsored by an individual(s), you must meet special conditions to receive Cash Aid and/or Food Stamps.

The Special Conditions Are:

- Your sponsor's income and resources will have to be reviewed for you to receive benefits. Your sponsor must provide information on the attached form. Both you and your sponsor must sign this form.
- If your application is approved, you and your sponsor will have to complete quarterly income and resource reports for Cash Aid and Food Stamp benefits. If your sponsor does not provide this information, your benefits may be changed or stopped. Family members who are not sponsored and are otherwise eligible can get and continue to get their benefits.
- **You are the person responsible for getting all the information requested to the county welfare department for both you and your sponsor.**

Important Information For Sponsors

The noncitizen you sponsor has applied for Cash Aid and/or Food Stamps. If you completed an affidavit of support, State regulations require the county welfare department to evaluate your income, resources, and property in deciding whether or not the noncitizen applicant can get benefits. Sponsorship is normally for an indefinite period of time. This form must be completed and signed by you under penalty of perjury. If you are living with your spouse or your spouse has signed an affidavit of support, your spouse's income, resources, and property are also counted.

If the noncitizen's application for Cash Aid is approved, **each quarter** you will have to report your income, resources, and property on the Sponsor's Quarterly Income and Resources Report (QR 72). The noncitizen will provide you with the report form. Your report must be completed and returned to the noncitizen immediately to ensure the noncitizen's continued eligibility. Each quarter, resources and a portion of your income will be used to determine the noncitizen's continued eligibility and benefits.

If the noncitizen receives benefits to which he or she is not entitled because you failed to accurately report information, you and/or the noncitizen may have to repay these benefits.

(Supplemental Application For Food Stamps And Cash Aid)

Noncitizen Name and Address

CASE NAME: _____

CASE NO:

WORKER NO: _____

1	YOUR NAME (FIRST, MIDDLE, LAST)	TELEPHONE NUMBER ()
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HOME ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)

MAILING ADDRESS (IF DIFFERENT THAN HOME ADDRESS)

2 YOUR SPOUSE'S NAME (IF LIVING TOGETHER OR SIGNED AN AFFIDAVIT OF SUPPORT) (FIRST, MIDDLE, LAST)	HAS SPONSOR'S SPOUSE SIGNED AN AFFIDAVIT OF SUPPORT? <input type="checkbox"/> Yes <input type="checkbox"/> No
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3 Do you or your spouse get assistance such as: California Work Opportunity and Responsibility to Kids (CalWORKs), Food Stamps, or Supplemental Security Income (SSI)? If Yes, complete below: ☐ Yes ☐ No

Case Name	Date of Birth	Type of Assistance	County	State

If **both** you and your spouse get Assistance and the noncitizen is **not** applying for Food Stamps, complete only the Certification section on Page 3 and return the form. For all others, go to Question **4**.

4 A. Have you or your spouse sponsored any other noncitizen's entry into the United States? ☐ Yes ☐ No
If Yes, complete below using the I-864, I-864A or the I-134:

Noncitizen Name	Noncitizen Address	Date of Admission to U.S.

B. Are any of the noncitizens listed in (4A) receiving any type of assistance such as: CalWORKs, Food Stamps or SSI? ☐ Yes ☐ No
If Yes, complete below:

Type of Assistance	Date First Applied	County	State

5 Do you or your spouse have other persons who are claimed or could be claimed as dependents for federal income tax purposes? ☐ Yes ☐ No
If Yes, complete below:

Name of Person(s)	Does Person Live With Sponsor	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No

VERIFIED:

☐ Letter on File☐ Verbal Communication☐ Other: _____

VERIFIED:

☐ Affidavit of Support

on File

☐ I-864

☐ I-864A

I-134

☐ Other:☐ Verified

☐ Verified

☐ IRS Form 1040 Reviewed☐ Other: _____

Claimed ☐ Yes ☐ No

Claimed ☐ Yes ☐ No

Claimed ☐ Yes ☐ No

Claimed ☐ Yes ☐ No

Claimed ☐ Yes ☐ No

6 Are you or your spouse currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete section below. Attach paystubs or other proof of earnings. If you or your spouse are self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.							COUNTY USE ONLY		
Name	Name of Employer	Gross Pay (Before Deductions)	How Often Paid (Weekly, Monthly, etc.)	Commissions or tips	Number of Tax Dependents Claimed	Check if Exempt	Enter Date Viewed Pay Stubs Other		
		\$		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		\$		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No			

7 Do you or your spouse receive or expect to receive any other income such as: Social Security, Unemployment/Disability Insurance, Child/Spousal Support, Veterans Benefits, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete section below and attach proof of the income.					
Name	Type of Income	Amount	How Often Received	Check if Exempt	Specify Verification and Date Reviewed:
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		\$		<input type="checkbox"/> Yes <input type="checkbox"/> No	

8 Do you or your spouse have any of the following resources? Check each item. If Yes, explain below.					
Resource	Sponsor	Spouse	Resource	Sponsor	Spouse
Checks or Money (At Home or Elsewhere)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trust Funds	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Checking, Savings, Credit Union Account	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stocks, Bonds, Certificates	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Notes, Mortgages, Trust Deeds, Sales Contracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Specify below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Resource	Owner	Current Value	Location (Home, Bank, Address, etc.)	Account Number	Check if Exempt
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No

9 Do you or your spouse own (or are you buying) any real property, such as: a house, land, building, etc. If Yes, complete section below: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Name	Type of Property	Address/Location	How Used? (Home, Rent, etc.)	Balance Owed	Value	Name of Mortgage Co.
				\$	\$	
				\$	\$	

10 Do you or your spouse own or use or are you buying any motor vehicles, such as: a car, truck, boat, trailer, van, camper, motorcycle, etc. If Yes, complete section below: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name	Year, Make, Model	License Number and State of Registration	Amount of current License Fee	Balance Owed	Check if Exempt
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

11 Do you or your spouse who receive income pay any court ordered support? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, enter the monthly amount \$_____ Who pays? _____		<input type="checkbox"/> Verified <input type="checkbox"/> Verified	
12 Do you or your spouse make support payments to other persons not living in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete section below:		<input type="checkbox"/> Verified <input type="checkbox"/> Verified	
Who Pays	To Whom Paid (Name)		Amount Paid
			\$
			\$
			\$

13 Do you or your spouse own or use personal property or resources such as: Jewelry, equipment, instruments, livestock, etc.? Do not list clothing, wedding rings, rugs, furniture, appliances, other household furnishings. If Yes, complete section below: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name	Name of Item	Date of Purchase	Purchase Price	Gift	Amount Owed
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	

CERTIFICATION

- I understand that if on purpose I don't give the right facts or all the facts for the CalWORKs, Food Stamp or cash-based Medi-Cal Programs, I can be punished and I can be legally accused of the crime of fraud. If I am found guilty of committing fraud, I can be fined up to \$10,000 for CalWORKs and \$250,000 for Food Stamps. And, I can go to jail/prison for up to 5 years for CalWORKs and 20 years for Food Stamps. In the CalWORKs and Food Stamp Programs, my benefits can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years, 10 years or forever.
 - I understand that the information provided on this form may be verified by local, state and federal agencies.
 - I understand that the noncitizen's case, including my statement, may be selected for an additional review to ensure that the noncitizen's eligibility was determined correctly.
 - I understand that I may be required to repay any benefits which are overpaid because of incorrectly or incompletely reported information.
- If the noncitizen is applying for Cash Aid, both you and your spouse must sign the form. If the noncitizen is applying for Food Stamps only, either you or your spouse must sign the form.

SPONSOR'S CERTIFICATION:

- I understand that the term for Sponsorship is normally an indefinite period of time.
- I declare under penalty of perjury under the laws of the United States of America and the State of California that the above information contained on this statement of facts is true, correct, and complete.

SPONSOR'S SIGNATURE OR MARK	DATE
SPONSOR'S SPOUSE'S SIGNATURE OR MARK (IF LIVING WITH SPOUSE OR HAS SIGNED AN AFFIDAVIT OF SUPPORT)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

- If the noncitizen is applying for Cash Aid, the noncitizen must sign this form. If the noncitizen is applying for Food Stamps only, the form must be signed by the noncitizen, the head of household, a household member, or an authorized representative.

NONCITIZEN'S CERTIFICATION:

- I have reviewed this signed and completed form from my sponsor(s). I declare under penalty of perjury under the laws of the United States of America and the State of California that it is true, correct, and complete to the best of my knowledge.

NONCITIZEN'S OR DECLARANT'S SIGNATURE OR MARK	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

COUNTY USE ONLY

Evaluation of Sponsor/Sponsor's Spouse Real/Personal Property Resources		CalWORKs Sponsor/Sponsor's Spouse Income Computation		Food Stamp Sponsor/Sponsor's Spouse Computation	
A. ITEMS	VALUE	A. Earned Income	\$	A. Earned Income	\$
	\$	B. Unearned Income	+	B. Less 20%	-
	\$	C. Subtotal	=	C. Unearned Income	+
	\$	D. Total number of sponsored noncitizens applying for/receiving CalWORKs		D. Gross Income Deduction for Sponsor's household size	-
B. Total	\$	E. Divide C by D	=	E. Subtotal	=
	CW FS	F. Number of sponsored noncitizens in this AU		F. Total number of sponsored noncitizens replace applying for/receiving Food Stamps	
C. Less: Food Stamp Deduction (\$1500)	NA \$1500	G. Total (Multiply E by F)	=	G. Total (Divide E by F)	=
D. Equals Subtotal	=				
E. Total number of sponsored noncitizens applying for/receiving CW/FS					
F. Total (Divide D by E)	=				
Amount in F to be included in each noncitizen's property limits.		Amount in G to be deemed income for entire AU.		Amount in G to be deemed income for each sponsored noncitizen.	

WORKER SIGNATURE	WORKER SUPERVISOR	DATE
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SPONSOR'S QUARTERLY INCOME AND RESOURCES REPORT

GIVE THIS TO YOUR SPONSOR

COMPLETE, SIGN, DATE AND RETURN THIS FORM AFTER:

THIS REPORT IS FOR THE MONTH OF

CASE NAME	CASE NUMBER
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SPONSOR'S INSTRUCTIONS

- You and your spouse (if living together or if spouse has signed an affidavit of support) must complete and sign this report and return it immediately to the noncitizen you sponsor.
- The noncitizen must complete, sign and date the form, and return it to the county by the 5th of the month. If a complete report, including verification, is not received by the 11th of the month, the noncitizen's Cash Aid may be delayed, lowered, or stopped.
- Call the county if you need help completing this form.

- Noncitizen's Name and Address

WORKER:

PHONE:

1 Sponsor's Name (First, Middle, Last)**Answer the following questions for your spouse if she/he is living with you OR has signed an affidavit of support.****2** Sponsor's Spouse's Name (If Living Together) (First, Middle, Last) Has sponsor's spouse signed an affidavit of support? ☐ YES ☐ NO**3** Do you and/or your spouse receive Cash Aid, such as California Work Opportunity and Responsibility to Kids (CalWORKs) or Supplemental Security Income (SSI)? ☐ YES ☐ NO
If YES, complete below.

CASE NAME	DATE OF BIRTH	TYPE OF CASH AID	COUNTY	STATE

4 During the report month did you and/or your spouse receive income, money or benefits, such as: earnings, training payments, earned income tax credit, strike benefits, social security, railroad retirement, unemployment or disability insurance, interest, worker's compensation, SSI/SSP, child/spousal support, loans, grants, tax refund, cash gifts, free housing/utilities, etc.? ☐ YES ☐ NO

If YES, list who received income, employer's name or other source of income, gross amount before deductions, and actual date received. Attach paystubs or other proof of earnings for the report month. Attach proof of any other income only when it starts and when it changes.

If self-employed, list business expenses on a separate sheet of paper and attach proof of income and expenses.

NAME	SOURCE	AMOUNT \$ DATE RECEIVED	AMOUNT \$ DATE RECEIVED	AMOUNT \$ DATE RECEIVED	AMOUNT \$ DATE RECEIVED	AMOUNT \$ DATE RECEIVED

NAME	SOURCE	AMOUNT \$ DATE RECEIVED	AMOUNT \$ DATE RECEIVED	AMOUNT \$ DATE RECEIVED	AMOUNT \$ DATE RECEIVED	AMOUNT \$ DATE RECEIVED

If both you and your spouse (who is living with you) receive Cash Aid, skip to Question 10 and complete the Certification Section.

5 Since your last quarterly report, did you or your spouse have any changes in personal and/or real property, such as: Receive, buy, sell or give away a motor vehicle, camper, boat, land or house, etc.? ☐ YES ☐ NO
If YES, explain the type of change, date of change and the amount, if applicable.**6** Did you or your spouse have a checking, savings or credit union account at the end of the report month? ☐ YES ☐ NO
If YES, complete below.

<input type="checkbox"/> Credit Union	Balance On Last Day of Report Month	Whose Account?	<input type="checkbox"/> Credit Union	Balance On Last Day of Report Month	Whose Account?
<input type="checkbox"/> Checking			<input type="checkbox"/> Checking		
<input type="checkbox"/> Savings	\$		<input type="checkbox"/> Savings	\$	

COUNTY USE ONLY

WORKER INITIALS

DATE

7 Since your last quarterly report, was there a change in the number of persons who are claimed as dependents for federal income tax purposes by you or your spouse? If YES, complete below. ☐ YES ☐ NO

NAME OF PERSON(S)	DOES PERSON LIVE WITH SPONSOR?	DATE OF CHANGE	EXPLAIN WHAT CHANGED
	<input type="checkbox"/> YES <input type="checkbox"/> NO		
	<input type="checkbox"/> YES <input type="checkbox"/> NO		

8 Since your last quarterly report, was there any change in payments made to persons who are claimed as federal tax dependents who are not living with you or your spouse? If YES, explain what changed, list the name of the person(s), amount paid and who paid: ☐ YES ☐ NO

9 During the report month, did you or your spouse pay any court-ordered support? If YES, enter the amount paid and attach receipts: \$ ☐ YES ☐ NO

10 Do you or your spouse have any other information to report such as: a new address, a change in the number of noncitizens that you sponsor and who will receive Cash Aid, recent or anticipated changes in income, etc.? ☐ YES ☐ NO
If YES, explain the change and if it is expected to be temporary or permanent, and give the date of change.

CERTIFICATION SECTION

- I understand that the term for Sponsorship is normally an indefinite period of time.
- I understand that failure to report information or misrepresentation of facts for Cash Aid can result in legal prosecution with penalties of a fine, imprisonment or both.
- I understand that I may be required to repay any benefits which are overpaid because of incorrectly or incompletely reported information.

SPONSOR'S CERTIFICATION

- I declare under penalty of perjury under the laws of the State of California that the information contained in this report is true and correct and is complete.

SIGNATURE OF SPONSOR	DATE
SIGNATURE OF SPONSOR'S SPOUSE (IF LIVING TOGETHER OR SIGNED AN AFFIDAVIT OF SUPPORT)	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

NONCITIZEN'S CERTIFICATION

- I have reviewed this signed and completed report from my sponsor(s). I declare under penalty of perjury under the laws of the State of California that, to the best of my knowledge, the information contained in this report is true and correct and is complete.

NONCITIZEN'S OR DECLARANT'S SIGNATURE OR MARK	DATE
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR OTHER PERSON COMPLETING FORM	DATE

COUNTY USE ONLY

Evaluation of Sponsor/Sponsor's Spouse Real/Personal Property Resources			CalWORKs Sponsor/Sponsor's Spouse Income Computation			Food Stamps Sponsor/Sponsor's Spouse Income Computation						
A.	ITEMS	VALUE	A.	Earned Income	\$ _____	A.	Earned Income	\$ _____				
	_____	\$ _____	B.	Unearned Income	+ _____	B.	Less 20%	- _____				
	_____	\$ _____	C.	Subtotal	= _____	C.	Unearned Income	+ _____				
	_____	\$ _____	D.	Total number of sponsored noncitizens applying for/receiving CalWORKs	_____	D.	Gross Income Deduction for sponsor's household size	- _____				
	_____	\$ _____	E.	Divide C by D	= _____	E.	Subtotal	= _____				
B.	Total	\$ _____	F.	Number of sponsored noncitizens in this AU	_____	F.	Total number of sponsored noncitizens applying for/receiving Food Stamps	_____				
C.	Less: Food Stamp Deduction (\$1500)	<table><tr><td>CW</td><td>FS</td></tr><tr><td>- NA</td><td>\$1500</td></tr></table>	CW	FS	- NA	\$1500	G.	Total (Multiply E by F)	= _____	G.	Total (Divide E by F)	= _____
CW	FS											
- NA	\$1500											
D.	Subtotal	= _____										
E.	Total number of sponsored noncitizens applying for/receiving CW/FS	_____										
F.	Total (Divide D by E)	= _____										
Amount in F to be included in each noncitizen's property limits.			Amount in G to be deemed income for entire AU.			Amount in G to be deemed income for each sponsored noncitizen.						



COVERSHEET TO THE APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY MEDICAL SERVICES PROGRAM (CMSP)

TO APPLY FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY CMSP, complete Items 1-13 on the attached application, and sign the Certification Section (Item 19). Give the form to the welfare office. If you have a disability and need help to apply for or keep getting cash aid, benefits, and services, tell the county.

BEFORE YOU CAN GET CASH AID, FOOD STAMPS, OR MEDI-CAL/34-COUNTY CMSP, INCLUDING IMMEDIATE NEED, HOMELESS ASSISTANCE, OR FOOD STAMP EXPEDITED SERVICE, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. We use the facts you give us to figure eligibility and benefits.

FOR CASH AID AND FOOD STAMPS, the county will tell you if and when you need to be fingerprint and photo imaged in order to get benefits.

TO GET IMMEDIATE NEED AND/OR HOMELESS ASSISTANCE, you must appear to be eligible for Cash Aid. Complete the attached form and give us the facts we ask for. You may need to meet some rules, such as giving us your social security number(s), trying to get income available to you, and agreeing to cooperate with the local child support agency about child, spousal, and medical support.

FOR FOOD STAMPS, the application can be filled in and signed under penalty of perjury by either an adult household member or by an authorized representative. If you are not an adult member of the household, you must have a written note signed by the head of household or another adult household member saying that you can apply for the household, pick up their food stamps, and/or use the food stamps to buy food for the household.

FOOD STAMPS — Date of Eligibility

If you are eligible for food stamps, we will figure your benefits from the date you apply. You can apply for food stamps the first day you contact the welfare office.

CASH AID IMMEDIATE NEED

If you have an emergency, you may be able to get up to \$200 while we work on your application. You will need to tell us about your emergency situation and you will need to show that you do not have the income or money to pay for these emergencies:

- Lack of housing or lack of food
- Eviction notice
- No utilities or utility shut-off notice
- Lack of essential clothing
- Essential transportation needs not met
- Other kinds of emergencies important to health and safety.

If your Immediate Need request is turned down, you can ask for it again during the time we work on your application. Let the county know if something changes.

CASH AID HOMELESS ASSISTANCE

If you are homeless, or have received a Pay Rent or Quit Notice, and want to apply for homeless assistance, tell the county. Homeless Assistance is available once in a lifetime, with exceptions.

CalWORKs DIVERSION SERVICES

Diversion services can help applicants who need some assistance but do not want or need to go on welfare. Diversion services allow you to choose to get a lump sum cash payment or non-cash services instead of going on aid. You can only choose to get Diversion services at time of application for cash aid, and you may be eligible for Medi-Cal, child care assistance, and food stamps if you get Diversion services.

After reviewing your facts, the county will tell you if you would be eligible for Diversion services. If eligible and you choose to get a Diversion cash payment or non-cash services instead of cash aid:

- You will get a denial notice for cash aid.
- Your cash aid may be lowered or the amount of time you can get cash aid may be reduced if you go on aid later.

APPLICANTS FOR FOOD STAMPS: All you have to do the day you apply is give us your name and address, tell us you want food stamps (Item 8) and sign the application (Item 19). Before we can tell if you are eligible, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. You should be told if you are eligible within 30 days after you apply.

FOOD STAMP EXPEDITED SERVICE

You may have the right to get food stamps within three days. Your household must be eligible for the Food Stamp Program AND HAVE:

- Rent or mortgage and utility costs that are more than your liquid resources and this month's income before deductions (**see the other side of the page for definitions of income and liquid resources**),
OR
- No more than \$100 liquid resources and less than \$150 income for the month before deductions,
OR
- No more than \$100 liquid resources and at least one member who is a migrant or seasonal farmworker.

Before you can get food stamps within three days, **complete Items 1 - 17 on the attached application**; give us all the facts we ask for during your eligibility interview; and give us proof of your identity.

MEDI-CAL PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN

If you are pregnant, you may get temporary Medi-Cal from certain medical providers for many prenatal care services before applying for regular Medi-Cal. Ask your doctor or clinic if they offer PE. If you apply for CalWORKs or Medi-Cal by the end of the month after the month you get a PE card, your temporary Medi-Cal will continue until aid is approved or denied. If you are getting PE, tell the county and check "YES" in both parts of Item 12.

MEDI-CAL/34-COUNTY CMSP - MEDICAL EMERGENCY/PREGNANCY

If you have a medical emergency or are pregnant AND want Medi-Cal/34-County CMSP as soon as possible, complete Items 1-13. You must also give all the facts we ask for during your eligibility interview and meet all eligibility requirements.

WHAT WE MEAN WHEN WE SAY:

- **CalWORKs:** California Work Opportunity and Responsibility to Kids Program.
- **Cash Aid:** Aid from CalWORKs and/or Refugee Cash Assistance (RCA) programs.
- **Diversion Services:** A lump sum cash payment or non-cash services instead of going on cash aid.
- **Food Stamps:** Benefits for low income households to help buy food.
- **Food Stamp Expedited Service:** Getting food stamps within 3 days.
- **Medi-Cal:** Medically necessary benefits for eligible persons.
- **Medi-Cal Presumptive Eligibility (PE):** Temporary Medi-Cal coverage from certain doctors or clinics for many out-patient prenatal care services.
- **34-County CMSP:** Medically necessary benefits for eligible adults who are not on Medi-Cal and who live in some rural counties.
- **Restricted Medi-Cal:** Medical Care for emergency and pregnancy only.
- **Restricted 34-County CMSP:** Emergency care only.
- **Authorized Representative:** A person picked by an applicant or recipient for food stamps and/or Medi-Cal, who can take care of some of their business.
- **Head of Household:** A responsible member of the food stamp household.
- **Income:** Money received or expected, such as:
 - Earnings, welfare, child/spousal support, Supplemental Security Income/State Supplementary Program (SSI/SSP), or Cash Assistance Program for Immigrants (CAPI);
 - Unemployment Insurance Benefits (UIB), State Disability Insurance (SDI), Veterans Benefits (VA), or other disability payments;
 - Strike funds; payments from roomers and boarders; school grants and loans;
 - Cash gifts, cash winnings, any other cash payments.
- **Liquid Resources:** Money other than income, such as:
 - Cash on hand, uncashed checks; money in checking accounts, savings accounts; or saving certificates;
 - Trust deeds, notes receivable, stocks or bonds, etc.
- **Utilities:** Gas, electricity, heating fuel, telephone (basic rate), utility installation, garbage and trash pickup, water, sewage, etc.
- **You, Anyone, Everyone:** Any and all persons who live in your home.

OTHER THINGS YOU SHOULD KNOW:

- You can apply for cash aid, food stamps and Medi-Cal at the same time and have one interview for all.
- You have the right to fill out this form yourself or, if you ask, have someone help you.
- **OVERPAYMENTS/OVERISSUANCES:** means you got more cash aid or benefits than you should have gotten. You will have to pay it back even if the county made an error. Your cash aid or food stamps will be lowered or stopped. Your Medi-Cal/34-County CMSP share of cost may be changed.

- **FRAUD AND PERJURY:** Fraud and perjury are crimes. The law says you must sign a penalty of perjury statement on most forms to get and to keep getting cash aid, food stamps, and Medi-Cal/34-County CMSP. Perjury means that you lied when you swore under oath to give true, correct, and complete facts. If you lie about facts or **on purpose** do not give us all the facts or situations that affect your eligibility and aid payment levels, you can be charged with fraud.
- **If you are found guilty of committing fraud, you may be fined up to \$10,000 for cash aid and \$250,000 for food stamps and/or sent to jail/prison for 3 years for cash aid and 20 years for food stamps. Cash aid and/or food stamps can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years, 10 years, 20 years or forever; and for Refugee Cash Assistance, 3 months and 6 months.**
- **SOCIAL SECURITY NUMBER (SSN) RULES:** We computer match SSNs against records from tax, welfare, employment, the Social Security Administration, and other agencies to be sure you are reporting all your income and resources. We may check out differences with employers, banks, and/or others. We also match SSNs to be sure that you are not getting aid in more than one case, or in another county or state; and for cash aid and food stamps, with law enforcement agencies for outstanding arrest warrants.

Cash aid and food stamps: You must give us the SSN for each applicant/recipient for cash aid and/or food stamps. If you refuse to give us either the SSN or proof of application for the SSN, you will not be able to get cash aid or food stamps. For cash aid, you must give us your SSN(s) or proof of application for the SSN within 30 days of application and give the SSN to the county when you get it.

Medi-Cal/34-County CMSP: Each applicant for Medi-Cal/34-County CMSP who has a SSN is asked to give it to the county. Any U.S. citizen, U.S. national, amnesty alien with a valid and current I-688, noncitizen with lawful permanent residence in the U.S. (LPR), or noncitizen permanently residing in the U.S. under color of law (PRUCOL) who refuses to give an SSN or proof of application for an SSN, will not be able to get Medi-Cal/34-County CMSP and who is not an amnesty alien with a valid and current I-688 or an LPR or PRUCOL, can still get restricted Medi-Cal/34-County CMSP if he/she meets all eligibility rules, including California residency.

COMPLAINTS

If you think you have been discriminated against, contact your county's civil rights representative or write to:
State Civil Rights Bureau
P.O. Box 944243
Sacramento, CA 94244-2430
or call collect (916) 654-2107
or for the hearing or speech impaired
TDD 1 - (916) 654-2098

For other kinds of complaints, contact your county first. If you and the county cannot agree, write or call to:
Public Inquiry and Response (PIAR)
744 P Street, M.S. 6-23
Sacramento, CA 95814
Phone 1 - (800) 952-5253
or for the hearing or speech impaired
TDD 1 - (800) 952-8349

STATE HEARINGS

You must ask for the hearing within 90 days of the county's action and you must tell why you want a hearing. You can ask for a State Hearing by writing to your local county appeals office or by calling one of the phone numbers listed for PIAR above, if you:

- Do not agree with any action taken by the county, or
- Are asking for a state hearing for cash aid, food stamps, Medi-Cal.

To appeal all 34-County CMSP eligibility issues, you can **only write** to your county.

APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY CMSP**Before completing this application, read the coversheet. If you need more space to answer, write on the back of this sheet.**

1. NAME OF APPLICANT (FIRST, MIDDLE INITIAL, LAST)		2. SOCIAL SECURITY NUMBER (SSN)		COUNTY USE ONLY	
3. MAIDEN OR OTHER NAME (IF ANY)		2A. DATE OF BIRTH (MM-DD-YYYY)			
4. HOME ADDRESS: NUMBER STREET		5. MAILING ADDRESS (IF DIFFERENT)			
CITY STATE ZIP CODE		CITY STATE ZIP CODE			
6. TELEPHONE NUMBER(S): HOME WORK MESSAGE () () ()				CASE NAME	
7. Is your home address permanent? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO HOME If not permanent, please explain:				CASE NUMBER	
8. Is anyone applying for: Cash Aid <input type="checkbox"/> YES <input type="checkbox"/> NO Food Stamps <input type="checkbox"/> YES <input type="checkbox"/> NO Medi-Cal <input type="checkbox"/> YES <input type="checkbox"/> NO 34-County CMSP <input type="checkbox"/> YES <input type="checkbox"/> NO Any Other Program(s) <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain:				DATE RECEIVED	
9. Has anyone ever asked for or gotten aid or benefits, including Medi-Cal/34-County CMSP/Medicaid or Diversion cash or non-cash services? If "YES", list: <input type="checkbox"/> YES <input type="checkbox"/> NO				TYPE OF APPLICATION:	
				CA: <input type="checkbox"/> CA <input type="checkbox"/> RCA FS: <input type="checkbox"/> Initial <input type="checkbox"/> Recert <input type="checkbox"/> Rest MC: <input type="checkbox"/> CMSP: <input type="checkbox"/>	
				Homeless:	
				FS: <input type="checkbox"/> YES <input type="checkbox"/> NO CA: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CW 42	
10. The law says we must record your ethnic group, race and language. This won't affect your eligibility. A. ETHNICITY (Everyone must also answer B) Are you Hispanic or Latino? <input type="checkbox"/> YES <input type="checkbox"/> NO B. RACE/ETHNIC ORIGIN - Check all boxes that apply to you. If you do not complete this question the county will do it for you. <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian (If checked, please select one or more of the following) <input type="checkbox"/> Filipino <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Laotian <input type="checkbox"/> Other Asian (specify) _____ <input type="checkbox"/> Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Other (specify) _____ C. PRIMARY LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Lao <input type="checkbox"/> Tagalog <input type="checkbox"/> American Sign <input type="checkbox"/> Cantonese <input type="checkbox"/> Cambodian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Russian <input type="checkbox"/> Other (specify) _____		TYPE OF AID/BENEFIT DATE(S) RECEIVED		Ethnic Group:	
				Race:	
				Primary Language:	
11. Is anyone a migrant or seasonal farmworker? <input type="checkbox"/> YES <input type="checkbox"/> NO				CA I.N.	
12. Is anyone pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", did she get a Presumptive Eligibility card? <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> Denied/NOA prep	
13. Does anyone have a personal emergency? If "YES", check (✓) type: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Immediate Medical Need <input type="checkbox"/> Pregnancy <input type="checkbox"/> Child Abuse <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Elder Abuse <input type="checkbox"/> Other emergency which threatens health or safety. Explain:				<input type="checkbox"/> Approved	
IF YOU NEED: CASH AID IMMEDIATE NEED PAYMENTFILL IN ITEMS 14 - 18. FOOD STAMP EXPEDITED SERVICEFILL IN ITEMS 14 - 17.				<input type="checkbox"/> Expedited Grant	
14. How much liquid resources does everyone, including children, have? <input type="checkbox"/> Cash, uncashed checks or money orders \$ _____ <input type="checkbox"/> Checking/savings or credit union account(s) \$ _____ <input type="checkbox"/> Trust deeds, notes receivable, stocks or bonds \$ _____ <input type="checkbox"/> Other (explain) \$ _____		17. How much are your utilities that are not included in your rent this month? \$		<input type="checkbox"/> Applicant requested CWD to complete SAWS 1 () (Initials)	
15. How much income did everyone, including children, get or will they get this month? Date Amount Date Amount \$ \$ \$ \$		18. Do you have an eviction notice or notice to pay or quit?		FS E.S.	
16. How much is your rent or mortgage this month? \$		Have your utilities been shut off or do you have a shut-off notice?		<input type="checkbox"/> E.S. questions not completed	
		Will your food run out in 3 days or less?		<input type="checkbox"/> Screened for E.S. Date _____ () (Initials)	
		Do you need essential clothing, such as diapers or clothing needed for cold weather?		FS Referral for:	
		Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?		<input type="checkbox"/> E.S. Processing	
I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand the statements I have made on this form may be checked and verified.				<input type="checkbox"/> Regular Processing	
I certify that if I have applied for Food Stamps the county has told me of my right to Expedited Service.				<input type="checkbox"/> CWD records cleared	
I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete.				<input type="checkbox"/> MEDS CDB cleared	
19. SIGNATURE (OR MARK) OF APPLICANT OR AUTHORIZED REPRESENTATIVE		DATE SIGNED		COUNTY OF APPLICATION	
SIGNATURE OF WITNESS TO MARK OR INTERPRETER		DATE SIGNED		COUNTY OF RESIDENCE (IF DIFFERENT)	
				TRANSITIONING CASE NUMBER	



STATEMENT OF FACTS FOR CASH AID, FOOD STAMPS, AND MEDI-CAL/ 34-COUNTY MEDICAL SERVICES PROGRAM (CMSP)

- Fill in the answers to all questions about the benefit(s) you are asking for. Print all answers in ink. The "CA" for Cash Aid, "FS" for Food Stamps, and "MC" for Medi-Cal/34-County CMSP listed to the left of each question tell you which questions are for each program.
- Give any proof (such as bills, receipts and records) to support your answers. Tell your worker when you need help in getting proof or in filling out this form. If you need more space, attach another sheet.
- If you are asking for Food Stamps and you are not an adult member of the household, attach a written authorization signed by the head of household or other adult member.

CA FS MC	① A. Person applying, or caretaker relative of child(ren) for whom aid is wanted.		HOME PHONE ()
	NAME:		
	HOME ADDRESS (NUMBER, STREET)	MAILING ADDRESS (IF DIFFERENT)	DAYTIME PHONE ()
	CITY	STATE	ZIP CODE
	CITY	STATE	ZIP CODE
FS	B. Are you homeless? If "YES": Are you temporarily staying in someone else's home? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	<input type="checkbox"/> YES <input type="checkbox"/> NO If "YES": Give date you began staying at this home:		
CA	C. Have you received a pay Rent or Quit Notice? <input type="checkbox"/> YES <input type="checkbox"/> NO		

② For each ADULT living in the home, give us all the facts.

CA FS MC	(A) ADULT'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National	
			<input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO	
	RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN)		BIRTHDATE (MONTH DAY YEAR)	SOCIAL SECURITY NUMBER
	SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	BIRTHPLACE CITY STATE COUNTRY
	TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> 34-County CMSP		MARITAL STATUS (✓) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed	

CA FS MC	(B) ADULT'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National	
			<input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO	
	RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN)		BIRTHDATE (MONTH DAY YEAR)	SOCIAL SECURITY NUMBER
	SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	BIRTHPLACE CITY STATE COUNTRY
	TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> 34-County CMSP		MARITAL STATUS (✓) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed	

CA FS MC	(C) ADULT'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National	
			<input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO	
	RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN)		BIRTHDATE (MONTH DAY YEAR)	SOCIAL SECURITY NUMBER
	SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	BIRTHPLACE CITY STATE COUNTRY
	TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> 34-County CMSP		MARITAL STATUS (✓) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed	

COUNTY USE ONLY

FS NON-HH/EXCLUDED MEMBER (63-402)	FS WORK/TRAINING EXEMPTIONS (63-407.21)	FS ABAWD EXEMPTIONS (63-410.3)
1. Separate HH (Purchase/prepare) (.12, .13)	a. Under 16/60 or older	1. ABAWD with FS Work/Training Exemption Code 63-407.21
2. Separate HH (Elderly/disabled) (.17)	a.(1) 16/17 not head of household; or	2. Under 18/50 or older (.321)
3. Roomer (must be listed in 13) (.211)	16/17 in school/training at least	3. Pregnant (.322)
4. Live-in attendant (.212)	1/2 time	4. Adult living in HH with dep. child (.323)
5. Other shared living quarters (.213)	b. Mentally/physically unfit for work	5. Lives in ABAWD exempt area (.33)
6. Ineligible alien (.221)	c. Mandatory participant in Welfare to Work activities	
7. Boarder (must be listed in 13) (.3)	d. Cares for child under 6 or incapacitated person	
8. SSN disqualified (.222)	e. Applicant for/recipient of UIB	
9. IPV disqualified (.223)	f. Participant in drug/alcohol program	
10. Workfare sanctioned (.225)	g. 30 hour week/min. x 30	
11. SSI/SSP recipient (.226)	h. 1/2 time student in school, training or higher education.	
12. Ineligible student (.227)		
13. Work req. disqualified (.228)		
14. Questionable Citizenship (300.51(b))		
15. Vol. quit ineligible (408.1, .2)		
16. Ineligible/disqualified ABAWD (410.4)		
17. Fleeing felon/parole or probation violator (.224)		
18. Drug felon (.229)		

COUNTY USE ONLY

CASE NAME	
CASE NUMBER	
WORKER	DATE RCD
<input type="checkbox"/> New <input type="checkbox"/> Restoration <input type="checkbox"/> Redetermine <input type="checkbox"/> Recertification <input type="checkbox"/> Residency Verified <input type="checkbox"/> FS ID <input type="checkbox"/> FS Aged/Disabled Verified <input type="checkbox"/> MC ID <input type="checkbox"/> MC Minor Consent: Exempt from ID, Residency, SSN, Verifs	

<input type="checkbox"/> AU	<input type="checkbox"/> NON-AU	<input type="checkbox"/> MFBU
FS Non-HH/Excluded Member Code:		
Work Registration/Exemption Codes:		
WELFARE to WORK	FS	ABAWD
VERIFIED: <input type="checkbox"/> Blind/Deaf/Disabled		
<input type="checkbox"/> SSN	<input type="checkbox"/> DED Packet	<input type="checkbox"/> Citizen
<input type="checkbox"/> Eligible Noncitizen	<input type="checkbox"/> SAVE	
Alien Reg. #	D.O.E.	

<input type="checkbox"/> AU	<input type="checkbox"/> NON-AU	<input type="checkbox"/> MFBU
FS Non-HH/Excluded Member Code:		
Work Registration/Exemption Codes:		
WELFARE to WORK	FS	ABAWD
VERIFIED: <input type="checkbox"/> Blind/Deaf/Disabled		
<input type="checkbox"/> SSN	<input type="checkbox"/> DED Packet	<input type="checkbox"/> Citizen
<input type="checkbox"/> Eligible Noncitizen	<input type="checkbox"/> SAVE	
Alien Reg. #	D.O.E.	

<input type="checkbox"/> AU	<input type="checkbox"/> NON-AU	<input type="checkbox"/> MFBU
FS Non-HH/Excluded Member Code:		
Work Registration/Exemption Codes:		
WELFARE to WORK	FS	ABAWD
VERIFIED: <input type="checkbox"/> Blind/Deaf/Disabled		
<input type="checkbox"/> SSN	<input type="checkbox"/> DED Packet	<input type="checkbox"/> Citizen
<input type="checkbox"/> Eligible Noncitizen	<input type="checkbox"/> SAVE	
Alien Reg. #	D.O.E.	

WWW WORK EXEMPTIONS (42-712)
Age under 16 (.41)
School Attendance (.42)
Age 60 or older (.43)
Disability (.44)
NCR caring for dependent or ward of the court or at risk of FC placement (.45)
Care of another ill or incap member of the household (.46)
Care of child:
- Age 6 months or under (or as allowed under county's CalWORKs plan) (.471)
- Member (who previously claimed .471) upon birth or adoption of subsequent child(ren) (.472)
Pregnancy (.48)
VISTA-full or part time volunteer (.49)

COUNTY USE ONLY

CA FS MC (A) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL <input type="checkbox"/> NONCITIZEN: SPONSORED <input type="checkbox"/> YES <input type="checkbox"/> NO		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓)		NON- AU (✓)	MFBU (✓)	MFG CHILD	FS Non-HH/Excluded Member Code:					
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE OR DUE DATE (Month, Day, Year)	AGE OF CHILD		DEATH DISABILITY ABSENCE UNEMPLOYMENT					<input type="checkbox"/> YES <input type="checkbox"/> MC: not in home, <input type="checkbox"/> NO 18-21 & tax dep.					
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO							CW 2.1 CW 371		Alien Reg. #		D.O.E.	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO											Work Registration/Exemption Codes:					
IF YES, NAME OF SCHOOL:											Welfare-to-Work FS					
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME										Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE <input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance				
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME												
CA FS MC (B) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL <input type="checkbox"/> NONCITIZEN: SPONSORED <input type="checkbox"/> YES <input type="checkbox"/> NO		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓)		NON- AU (✓)	MFBU (✓)	MFG CHILD	FS Non-HH/Excluded Member Code:					
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE OR DUE DATE (Month, Day, Year)	AGE OF CHILD		DEATH DISABILITY ABSENCE UNEMPLOYMENT					<input type="checkbox"/> YES <input type="checkbox"/> MC: not in home, <input type="checkbox"/> NO 18-21 & tax dep.					
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO							CW 2.1 CW 371		Alien Reg. #		D.O.E.	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO											Work Registration/Exemption Codes:					
IF YES, NAME OF SCHOOL:											Welfare-to-Work FS					
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME										Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE <input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance				
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME												
CA FS MC (C) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL <input type="checkbox"/> NONCITIZEN: SPONSORED <input type="checkbox"/> YES <input type="checkbox"/> NO		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓)		NON- AU (✓)	MFBU (✓)	MFG CHILD	FS Non-HH/Excluded Member Code:					
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE OR DUE DATE (Month, Day, Year)	AGE OF CHILD		DEATH DISABILITY ABSENCE UNEMPLOYMENT					<input type="checkbox"/> YES <input type="checkbox"/> MC: not in home, <input type="checkbox"/> NO 18-21 & tax dep.					
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO							CW 2.1 CW 371		Alien Reg. #		D.O.E.	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO											Work Registration/Exemption Codes:					
IF YES, NAME OF SCHOOL:											Welfare-to-Work FS					
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME										Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE <input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance				
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME												
CA FS MC (D) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL <input type="checkbox"/> NONCITIZEN: SPONSORED <input type="checkbox"/> YES <input type="checkbox"/> NO		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓)		NON- AU (✓)	MFBU (✓)	MFG CHILD	FS Non-HH/Excluded Member Code:					
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE OR DUE DATE (Month, Day, Year)	AGE OF CHILD		DEATH DISABILITY ABSENCE UNEMPLOYMENT					<input type="checkbox"/> YES <input type="checkbox"/> MC: not in home, <input type="checkbox"/> NO 18-21 & tax dep.					
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO							CW 2.1 CW 371		Alien Reg. #		D.O.E.	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO											Work Registration/Exemption Codes:					
IF YES, NAME OF SCHOOL:											Welfare-to-Work FS					
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME										Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE <input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance				
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME												

CA ④ List any parent(s) of the child(ren) or unborn who does not live in the home with you.				COUNTY USE ONLY	
NAME OF PARENT		REASON THE PARENT DOES NOT LIVE IN THE HOME		<input type="checkbox"/> Verif. on File <input type="checkbox"/> MC 13	
CA FS ⑤ Has anyone changed citizenship/immigration status in the last 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If "YES", complete below:					
NAME		WHAT CHANGED	DATE	ALIEN NUMBER (IF APPLICABLE)	
CA FS ⑥ A. Is a foster child living in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> CA and FC Elig/CR Chooses: Child: <input type="checkbox"/> CA <input type="checkbox"/> FC CR: <input type="checkbox"/> CA <input type="checkbox"/> None <input type="checkbox"/> Kin-GAP	
If "YES", who:					
FS B. Do you want the foster child(ren) and foster care income counted on the Food Stamp Case? <input type="checkbox"/> YES <input type="checkbox"/> NO					
CA FS ⑦ Has anyone ever used any other name (maiden, adoptive, etc.)? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If "YES", complete below:					
NAME		OTHER NAME(S) USED			
NAME		OTHER NAME(S) USED			
			YES	NO	
CA MC ⑧ A. Does everyone live in California? <input type="checkbox"/> YES <input type="checkbox"/> NO					Calif. Resident: <input type="checkbox"/> YES <input type="checkbox"/> NO
If "NO", explain:					
CA B. Does everyone plan to stay in California permanently?					<input type="checkbox"/> Property
CA C. Does anyone own, lease or maintain a home outside California?					<input type="checkbox"/> PA
CA MC D. Is anyone currently getting public assistance outside California? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If "YES", explain:					
CA E. Is anyone planning to leave California for more than 30 days?					
MC ⑨ Are you 18 to 21 years of age and claimed as a dependent for income tax purposes? <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> Tax Dependent Letter Sent <input type="checkbox"/> CA 2.1	
If Yes, who:					
CA FS ⑩ A. Has anyone's cash aid or food stamps been stopped due to: non-cooperation during a quality control review, work or training sanctions or failure to meet the Food Stamp Able Bodied Adults Without Dependent (ABAWD) work requirement, or for any other reason? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If "YES", explain below:					
NAME		WHY	WHEN	WHAT COUNTY/STATE	
CA FS B. Has anyone's cash aid or food stamps been stopped for a period of time or forever due to welfare fraud or a food stamp Intentional Program Violation? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If "YES", explain below:					
NAME		WHY	WHEN	WHAT COUNTY/STATE	
FS ⑪ Does anyone living with you buy food and fix meals separately from others in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO				Separate household eligible: <input type="checkbox"/> YES <input type="checkbox"/> NO	
If "YES", who:					
FS ⑫ Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO				Separate household eligible: <input type="checkbox"/> YES <input type="checkbox"/> NO	
If "YES", who:					

FS 13 A. Do you pay someone else for meals and/or a room? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						COUNTY USE ONLY																							
NAME OF PERSON YOU PAY		CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both		HOW MUCH \$		HOW OFTEN		NO. OF MEALS PER DAY																					
CA FS 15 B. Does anyone pay you for meals and/or a room?		CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both		HOW MUCH \$		HOW OFTEN		NO. OF MEALS PER DAY																					
NAME OF PERSON WHO PAYS YOU		NAME OF PROGRAM		NAME		NAME OF PROGRAM		HOUSEHOLD ELECTS BOARDER HH MEMBER																					
NAME		NAME OF CENTER, SHELTER, HOSPITAL, ETC.		DATE ENTERED		DATE EXPECTED TO LEAVE		ROOMER																					
FS 14 Does anyone get food from any of the following programs? <input type="checkbox"/> YES <input type="checkbox"/> NO • Communal dining facility for the elderly or disabled • Food distribution program operated by a Native American reservation • Other food program						FS Eligible Institution: <input type="checkbox"/> YES <input type="checkbox"/> NO CA Eligible: <input type="checkbox"/> YES <input type="checkbox"/> NO																							
CA FS MC 15 A. Does anyone live in any of the following: <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below: <div style="display: flex; justify-content: space-between;"> <div> • Shelter, center • Reservation for Native Americans • Psychiatric hospital/mental institution • Group living arrangement for the disabled/blind </div> <div> • Hospital or nursing home • Subsidized housing for the elderly • Drug or alcohol rehabilitation center • Board and care home • Penal institution/correctional facility </div> </div>																													
MC B. Does the person who is in a hospital or nursing home have a spouse or other family member at home? <input type="checkbox"/> YES <input type="checkbox"/> NO						School Attendance Verified: <input type="checkbox"/> YES <input type="checkbox"/> NO																							
CA 16 List any child age 6-18 who does not attend school regularly and explain why he/she is not attending regularly. <input type="checkbox"/> No Child Age 6-18																													
CA FS MC 17 A. Is anyone age 14 or older enrolled in school, college, or a training program? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						School Enrollment Verif.: <input type="checkbox"/> YES <input type="checkbox"/> NO Date Verified: FS Eligible Student: <input type="checkbox"/> YES <input type="checkbox"/> NO School Enrollment Verif.: <input type="checkbox"/> YES <input type="checkbox"/> NO Date Verified: FS Eligible Student: <input type="checkbox"/> YES <input type="checkbox"/> NO																							
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%;">NAME</td> <td style="width:10%;">AGE</td> <td style="width:25%;">NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM</td> <td style="width:20%;">ENROLLED (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):</td> <td style="width:15%;">UNITS/HOURS PER WEEK</td> <td style="width:10%;">WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td colspan="6" style="height: 40px;"></td> </tr> <tr> <td>NAME</td> <td>AGE</td> <td>NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM</td> <td>ENROLLED (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):</td> <td>UNITS/HOURS PER WEEK</td> <td>WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td colspan="6" style="height: 40px;"></td> </tr> </table>										NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	ENROLLED (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):	UNITS/HOURS PER WEEK	WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO							NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	ENROLLED (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):	UNITS/HOURS PER WEEK	WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	ENROLLED (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):	UNITS/HOURS PER WEEK	WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO																								
NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	ENROLLED (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):	UNITS/HOURS PER WEEK	WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO																								
CA FS B. Complete below for anyone enrolled in college or attending a similar educational institution.						Expenses Verified: <input type="checkbox"/> YES <input type="checkbox"/> NO Date Verified:																							
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">NAME</td> <td style="width:25%;">TERM (✓) CHECK STATUS <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter</td> <td style="width:20%;">TUITION/FEES PER TERM \$</td> <td style="width:30%;">BOOKS, EQUIPMENT, ETC., PER TERM \$</td> </tr> <tr> <td>MILES ROUND TRIP PER DAY TO SCHOOL/CHILD CARE</td> <td>DAYS ATTENDING PER WEEK</td> <td colspan="2">TRANSPORTATION USED</td> </tr> <tr> <td>TRANSPORTATION COST PER WEEK \$</td> <td>AMOUNT PAID PER WEEK BY CAR POOL MEMBERS \$</td> <td colspan="2">PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY \$</td> </tr> </table>										NAME	TERM (✓) CHECK STATUS <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$	MILES ROUND TRIP PER DAY TO SCHOOL/CHILD CARE	DAYS ATTENDING PER WEEK	TRANSPORTATION USED		TRANSPORTATION COST PER WEEK \$	AMOUNT PAID PER WEEK BY CAR POOL MEMBERS \$	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY \$									
NAME	TERM (✓) CHECK STATUS <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$																										
MILES ROUND TRIP PER DAY TO SCHOOL/CHILD CARE	DAYS ATTENDING PER WEEK	TRANSPORTATION USED																											
TRANSPORTATION COST PER WEEK \$	AMOUNT PAID PER WEEK BY CAR POOL MEMBERS \$	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY \$																											
CA 18 A. Is anyone under age 20 and pregnant or a parent? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						Referred to: <input type="checkbox"/> Cal-Learn <input type="checkbox"/> CW 25 <input type="checkbox"/> CW 25A <input type="checkbox"/> Referred to Welfare-to-Work																							
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:40%;">NAME</td> <td style="width:10%;">AGE</td> <td style="width:50%;">CHECK (✓) STATUS <input type="checkbox"/> Pregnant <input type="checkbox"/> Teen Parent</td> </tr> <tr> <td colspan="3" style="height: 40px;"></td> </tr> </table>										NAME	AGE	CHECK (✓) STATUS <input type="checkbox"/> Pregnant <input type="checkbox"/> Teen Parent																	
NAME	AGE	CHECK (✓) STATUS <input type="checkbox"/> Pregnant <input type="checkbox"/> Teen Parent																											
CA B. Has anyone received a cash bonus or penalty, or help with child care, transportation, etc. from the Cal-Learn Program? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						Financial Aid: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MC 210 S-E																							
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">NAME</td> <td style="width:30%;">WHERE (COUNTY)</td> <td style="width:40%;">DATE(S) RECEIVED</td> </tr> <tr> <td colspan="3" style="height: 40px;"></td> </tr> </table>										NAME	WHERE (COUNTY)	DATE(S) RECEIVED																	
NAME	WHERE (COUNTY)	DATE(S) RECEIVED																											
CA FS 19 Is anyone on strike? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						Striker Regs Apply: <input type="checkbox"/> CA <input type="checkbox"/> FS																							
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;">NAME OF STRIKER</td> <td colspan="5" style="height: 40px;"></td> </tr> <tr> <td>NAME OF UNION</td> <td colspan="5"></td> </tr> <tr> <td>DATE WENT ON STRIKE</td> <td colspan="5">MONTHLY INCOME (BEFORE DEDUCTIONS) EARNED FROM THIS JOB BEFORE THE STRIKE \$</td> </tr> </table>										NAME OF STRIKER						NAME OF UNION						DATE WENT ON STRIKE	MONTHLY INCOME (BEFORE DEDUCTIONS) EARNED FROM THIS JOB BEFORE THE STRIKE \$						
NAME OF STRIKER																													
NAME OF UNION																													
DATE WENT ON STRIKE	MONTHLY INCOME (BEFORE DEDUCTIONS) EARNED FROM THIS JOB BEFORE THE STRIKE \$																												

CA FS	(20)	Has anyone, including children, worked or does anyone expect to go to work, including part-time and occasional work? Check (✓) "YES" or "NO" for each item. If "YES", complete below:	YES	NO	COUNTY USE ONLY									
		Has anyone stopped or refused work or training within the last 60 days?			(A) (✓) if exempt FS S/E Farmer									
		Is anyone working or in training now?			CA MC <input type="checkbox"/> FS Adult <input type="checkbox"/> Yes <input type="checkbox"/> No									
		Does anyone expect to be working or in training in the next two months?			<input type="checkbox"/> FS Child									
If self-employed: For Food Stamps: List your business expenses on a separate sheet of paper. For Cash Aid: Check (✓) how you want your business expenses figured each month: <input type="checkbox"/> 40% standard deduction <input type="checkbox"/> Actual business expenses <input type="checkbox"/> Monthly average (yearly business costs divided by 12 months). If actual, you must list your business expenses on a separate sheet of paper.					(B) (✓) if exempt FS S/E Farmer CA MC <input type="checkbox"/> FS Adult <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> FS Child									
					<input type="checkbox"/> Verif(s) on file for: <input type="checkbox"/> (A) <input type="checkbox"/> (B)									
					FS: Work history last 120 days <input type="checkbox"/> (A) <input type="checkbox"/> (B)									
(A) NAME CA FS MC		NUMBER OF HOURS OF WORK/TRAINING PER MONTH LAST MONTH _____ THIS MONTH _____	EMPLOYER'S NAME AND ADDRESS											
PAY DATE(S)	SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	WAGES BEFORE DEDUCTIONS \$ _____ per	DATE LAST CHECK RECEIVED	RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", COMPLETE BELOW										
REASON FOR LEAVING JOB/TRAINING			LAST DAY OF WORK/TRAINING	AMOUNT RECEIVED \$ _____ AMOUNT EXPECTED \$ _____										
DATE NEXT CHECK EXPECTED	AMOUNT EXPECTED BEFORE DEDUCTIONS \$ _____	OCCUPATION												
(B) NAME CA FS MC		NUMBER OF HOURS OF WORK/TRAINING PER MONTH LAST MONTH _____ THIS MONTH _____	EMPLOYER NAME AND ADDRESS											
PAY DATE(S)	SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	WAGES BEFORE DEDUCTIONS \$ _____ per	DATE LAST CHECK RECEIVED	RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", COMPLETE BELOW										
REASON FOR LEAVING JOB/TRAINING			LAST DAY OF WORK/TRAINING	AMOUNT RECEIVED \$ _____ AMOUNT EXPECTED \$ _____										
DATE NEXT CHECK EXPECTED	AMOUNT EXPECTED BEFORE DEDUCTIONS \$ _____	OCCUPATION												
CA FS MC		(21) A. Does anyone pay for care of a child, disabled adult, or other dependent so he/she can go to work, school, or look for a job? <input type="checkbox"/> YES <input type="checkbox"/> NO			County Use Only: <input type="checkbox"/> Trustline Informing (CCP 2) <input type="checkbox"/> Health & Safety Certification (CCP 5) <input type="checkbox"/> Dependent Care Verified <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>DEP. CARE ELIGIBLE</td> <td>YES</td> <td>NO</td> </tr> <tr> <td>FS</td> <td></td> <td></td> </tr> <tr> <td>MC</td> <td></td> <td></td> </tr> </table> Is there another person in household who could provide care? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", who: _____	DEP. CARE ELIGIBLE	YES	NO	FS			MC		
DEP. CARE ELIGIBLE	YES	NO												
FS														
MC														
WHO GETS CARE	WHO PAYS	WHO GIVES CARE	<input type="checkbox"/> WORK <input type="checkbox"/> TRAINING	AMOUNT PAID/HOW OFTEN \$ _____ EVERY										
WHO GETS CARE	WHO PAYS	WHO GIVES CARE	<input type="checkbox"/> WORK <input type="checkbox"/> TRAINING	AMOUNT PAID/HOW OFTEN \$ _____ EVERY										
B. Does anyone else pay all or part of your child care costs? <input type="checkbox"/> YES <input type="checkbox"/> NO														
Include costs paid by a relative or friend not living in the home, Department of Education, Block Grant, etc. If "YES", complete below:														
NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID \$ _____	WHO ELSE PAYS	MONTHLY AMOUNT PAID \$ _____										
NAME OF CHILD	WHO PAYS	MONTHLY AMOUNT PAID \$ _____	WHO ELSE PAYS	MONTHLY AMOUNT PAID \$ _____										
FS MC (22) Does anyone pay child or spousal support? <input type="checkbox"/> YES <input type="checkbox"/> NO														
If "YES", complete below:														
WHO PAYS		FOR WHOM	AMOUNT PER MONTH \$ _____											
CA FS MC		(23) Has anyone, including children, applied for or received unemployment or disability insurance benefits in the last 12 months OR expect to receive these benefits in the future? <input type="checkbox"/> YES <input type="checkbox"/> NO												
If "YES", complete below:														
NAME	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED											
NAME	DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED											
CA (24) Has anyone received a Diversion cash payment or non-cash services from any county or other state? <input type="checkbox"/> YES <input type="checkbox"/> NO														
If "YES", complete below:														
NAME	COUNTY/STATE	AMOUNT RECEIVED \$ _____	LIST SERVICES RECEIVED	ESTIMATED VALUE OF SERVICES \$ _____										
DATE RECEIVED														

Employment History

Page 6 of 14

CA FS (25) Has any parent living in the home worked or been in training in the past 24 months? ☐ YES ☐ NO

If "YES", complete below:

- Include all work done in and outside the United States (U.S.).
- Include work done in exchange for something besides money, such as rent, food, utilities or **anything else**.
- Begin with each person's most recent job or training.

COUNTY USE ONLY

PE/UIB Requirements
Earnings from month prior to month of application

App Date: _____

Earnings from _____ to _____

MO/YR (25) A (25) B

\$ \$

A. NAME IS HE/SHE A NATIVE AMERICAN? ☐ YES ☐ NO

IF "YES", LIST TRIBE: _____

Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid
1. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	4. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
2. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	5. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
3. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	6. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

B. NAME IS HE/SHE A NATIVE AMERICAN? ☐ YES ☐ NO

IF "YES", LIST TRIBE: _____

Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid
1. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	4. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
2. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	5. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
3. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	6. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

FS (26) Are all Food Stamp household members citizens of the United States (U.S.)? ☐ YES ☐ NO

If "NO", complete below for each Food Stamp household member who is **not a citizen of the U.S.**

Name of each noncitizen	A. How many years total has this person, their spouse, and/or their parents (before this person was 18 years old) lived in the U.S.?	B. While living in the U.S., in how many of the years reported in Column A did this person, their spouse, and/or their parents (before this person was 18 years old) earn money by working in the U.S.?	C. While living outside the U.S., how many total years did this person, their spouse, and/or their parents (before this person was 18 years old) work in the U.S.?
1.			
2.			
3.			
4.			

TOTAL \$ \$

(25) A B

Tribal JOBS Referral

UIB Verif(s) on file

Must apply for UIB

CA FS MC (27) Has anyone been in the U.S. military service or the spouse, parent, or child of a person who has been in the military service? ☐ YES ☐ NO

If "YES", complete below:

NAME	U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	(✓) STATUS <input type="checkbox"/> ACTIVE DUTY MILITARY/VETERAN <input type="checkbox"/> SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO	BRANCH OF SERVICE	DATE OF SERVICE
NAME	U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	(✓) STATUS <input type="checkbox"/> ACTIVE DUTY MILITARY/VETERAN <input type="checkbox"/> SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO	BRANCH OF SERVICE	DATE OF SERVICE

Currently Receiving/Got/ or UIB eligible in last 12 months

UIB Ineligible Reason:

(26) FS: ☐ 40 Quarters Verif.

(27)

☐ CW 5

FS: Noncitizen's Honorable Discharge Verif.

☐ YES ☐ NO

COUNTY USE ONLY

PRINCIPAL EARNER (PE) *	DATE OF APPLICATION	QUARTER OF APPLICATION

*Principal Earner — the parent who earned the most income in the last 24 months prior to the month of application.

CA (28) A. Does anyone, including children, get or expect to get money from any source listed below?

Check (✓) "YES" or "NO" for each item.

	YES	NO		YES	NO
Work Study, Welfare-to-Work, or other program			VA (Veterans) educational related income		
Other training allowance			VA Aid & Attendance		
Educational grants, loans and scholarships			Social Security disability or supplemental security income/state supplementary payment (SSI/SSP)		
CalWORKs/Cash aid from another state			VA disability		
Refugee (RCA) Assistance			Railroad disability		
Cash Assistance Program for Immigrants (CAPI)			Other disability income from a federal, state, or local governmental agency		
GA/GR (General Assistance/Relief)			Other non-government disability or sick leave		
Workers Compensation			Social Security retirement or survivors		
Child/spousal support or money for medical bills or premiums			Railroad retirement		
Strike benefits			Other retirement income from a federal, state, or local governmental agency		
Loans, gifts, contributions			Other non-government retirement income		
Legal or insurance settlements/ court actions pending			Per capita payments		
Sales of notes, contracts, trust deeds, promissary notes			Winnings (gambling/lottery/bingo, prizes, etc.)		
Military allotment or pension			Other (Explain)		

COUNTY USE ONLY

- ☐ Casualty Unit Notified
☐ CWC 6041
☐ DHS 6155
☐ Verif(s) on File
Explain Anticip. Income
Workers Comp:
☐ Temporary ☐ Permanent

If "YES", complete below:

NAME	SOURCE	(AMOUNT RECEIVED BEFORE DEDUCTIONS)	WHEN	HOW OFTEN
		\$		
		\$		

(✓) if exempt

CA	FS	MC

CA B. Does anyone expect a change in the amount of money received now, such as a cost-of-living raise?

If "YES", complete below:

☐ YES ☐ NO

NAME	WHAT	AMOUNT \$	WHEN
------	------	-----------	------

CA (29) Does anyone get housing or rent, utilities, food or clothing free or in exchange for work?

If "YES", complete below and check (✓) if free or in exchange for work:

☐ YES ☐ NO

ITEM RECEIVED	Free	For Work	WHO RECEIVES THE ITEM	VALUE	WHO PROVIDES THE ITEM
Housing or rent				\$	
Utilities				\$	
Food				\$	
Clothing				\$	

In-Kind Income:

Verif. on file: ☐ YES ☐ NO

Partial	Full	Earned	Unearned

CA (30) A. Does anyone own or is anyone buying real estate, such as land and/or buildings anywhere, including outside the U.S.?

If "YES", complete below. Include land and/or buildings in which the title is shared.

☐ YES ☐ NO

TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✓)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME
	LIVE IN IT						
	RENTAL PROPERTY						
LISTED FOR SALE <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER (EXPLAIN):						
	LIVE IN IT						
	RENTAL PROPERTY						
LISTED FOR SALE <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER (EXPLAIN):						

Home Exempt ☐ YES ☐ NO

Other Real Property

Market Value \$

Amount Owed \$

Net Value \$

Lien Applicable ☐ YES ☐ NOListed for sale ☐ YES ☐ NOHome Exempt ☐ YES ☐ NO

Other Real Property

Market Value \$

Amount Owed \$

Net Value \$

Lien Applicable ☐ YES ☐ NOListed for sale ☐ YES ☐ NO**CA B. Does anyone own a house that is not lived in now that he/she hopes to return to someday?**

If "YES", complete below:

☐ YES ☐ NO

OWNER OF PROPERTY	PROPERTY ADDRESS	EXPECTED DATE OF RETURN (IF KNOWN)

Total countable property: Page 7 (List totals on page 9)

CA \$

FS \$

MC \$

CA
FS
MC**31) A. Does anyone, including children, have any of the following personal or business-related resources?** Check (✓) each item either "YES" or "NO".

Include all resources owned, used, controlled, shared or held jointly with any person(s) (even for convenience only). The county will determine whether or not these resources count.

	YES	NO		YES	NO
Cash (on hand or elsewhere)			Trust funds (whether or not available)		
Uncashed checks (on hand or elsewhere)			Notes, mortgages, deeds of trust, contracts of sale, etc.		
Savings accounts - children's and adult's			IRA or Keogh plans, etc.		
Checking accounts - whether or not they are used			Retirement funds which are available if you stop work (such as PERS, etc.)		
Credit union accounts			Employee deferred compensation plans		
Stocks, bonds, certificates of deposit, money market accounts, etc.			Life insurance or annuity		
Oil, mining, or mineral rights			Life estate interest in any property		
Burial trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items			Long term care insurance		
Income tax refund			EBT cash balance from a previous month		
			Other (explain)		

IF "YES", COMPLETE BELOW:

RESOURCE	BUSINESS-RELATED	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$

CA FS MC B. Does anyone get or expect to get money from any of the above resources, such as interest, dividends, etc.? ☐ YES ☐ NO

If "YES", complete below:

NAME	SOURCE OF MONEY	AMOUNT	HOW OFTEN	BUSINESS-RELATED
		\$		<input type="checkbox"/> YES <input type="checkbox"/> NO
		\$		<input type="checkbox"/> YES <input type="checkbox"/> NO

MC 32) Are there any liens recorded or did you sign a security agreement with a doctor, clinic, or hospital against any property owned by you or any family member that is used as security for health care services? ☐ YES ☐ NO

If "YES", complete below:

LIEN OR SECURED AMOUNT	TYPE AND LOCATION OF PROPERTY	DATE AND TYPE OF MEDICAL CARE RECEIVED/TO BE RECEIVED	NAME OF PROVIDER
\$			
\$			

MC 33) A. Does anyone own any personal property, such as: ☐ YES ☐ NO

- Non-motorboats, camper shells, non-motor trailers.
- Guns; tools; or sporting equipment, etc.
- Pets or livestock for personal use.
- Jewelry, artwork, antiques, collections, cameras, musical equipment (pianos, guitars, amplifiers, etc.).

If "YES", complete below: Do not include wedding and engagement rings or heirlooms. List jewelry worth more than \$100 and household goods or personal items worth more than \$500 per item.

ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED	ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$

MC B. Does anyone have any business property, including tools, inventory and materials, business equipment, livestock, etc.? ☐ YES ☐ NO

Include any property that is shared or held jointly with any other person(s). If "YES", complete below:

ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED	ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$

COUNTY USE ONLY

☐ Trust Fund/Not Court Ordered

☐ Court Petitioned Date _____

☐ Resource Verified: Explain how: _____

Total Value = \$ _____

☐ Burial Reserve or Trust (MCO) Amount Owed \$ _____

☐ Revocable

☐ Irrevocable

☐ Designated Fund and Current Value \$ _____

☐ CA Restricted Account

Check (✓) if exempt

CA	FS	MC

Verified: ☐ YES ☐ NOLien Applicable: ☐ YES ☐ NOSecurity Agreement: ☐ YES ☐ NOMC 174 completed and sent: ☐ YES ☐ NO☐ Owned Jointly☐ Owned Separately☐ Personal Property \$500 + for Pickle Program☐ Insignificant Value for 1931(b)☐ Listed for sale (Specify): _____

Total Countable Property: Page 8 (List totals on Page 9)

CA \$ _____

FS \$ _____

MC \$ _____

☐ Listed for sale (Specify): _____

CA MC FS (34) Has anyone sold, spent, traded, transferred, or given away any real property, such as a house or land; or personal property such as money, cars, bank accounts, money from a legal or accident insurance settlement, or anything else? (List any property sold or traded within the last 12 months for cash aid, 3 months for food stamps, and within the last 2 1/2 years (30 months) for Medi-Cal). If "YES", explain what and when: ☐ YES ☐ NO

CA MC (35) Does anyone own, have the use of or have their name on the registration of any motor vehicle, such as: automobile, motorcycle, snowmobile, recreational vehicle, motorboat, etc., even if not running? If "YES", complete below. Look at your registration to get facts for each vehicle: ☐ YES ☐ NO

	VEHICLE (1)		VEHICLE (2)		VEHICLE (3)	
OWNER OF VEHICLE						
NAME OF PERSON WHO USES VEHICLE						
YEAR/MAKE/MODEL						
LICENSE NUMBER						
ESTIMATED VALUE	\$		\$		\$	
BALANCE OWED	\$		\$		\$	
LICENSED	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
LEASED	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
HOW DO YOU USE THE VEHICLE? Check (✓) each item "YES" OR "NO."						
As a Home	YES	NO	YES	NO	YES	NO
To go to work or training or for job search						
For self-employment, self-support, or business use						
Needed for disabled household member						
To get household's fuel or water						
For recreational use only						

COUNTY USE ONLY

Transfer of Assets:

☐ CA in last 12 months

☐ FS in last 3 months

☐ Medi-Cal in last 30 months

LTC ONLY

☐ Adequate Consideration

☐ Spenddown

Total Nonexempt Property \$

Compute Vehicle Valuation in Section Below:

☐ Verifications viewed

☐ Leased vehicle:

☐ (1) ☐ (2) ☐ (3)

☐ Pickle Program: Use Pickle Handbook (Reference Section 9)

Vehicle Value
(Enter Date of blue book issue or other documentation)

(1) Date: _____ \$ _____

(2) Date: _____ \$ _____

(3) Date: _____ \$ _____

COUNTY USE ONLY - VEHICLES

CASH AID	VEHICLE (1)		VEHICLE (2)		VEHICLE (3)	
(A) Is vehicle a home, income producing, primary transportation to get fuel/water, or used for a disabled household member? (63-501.521)	<input type="checkbox"/> YES <input type="checkbox"/> NO (Exclude) Go to (B).	<input type="checkbox"/> YES <input type="checkbox"/> NO (Exclude) Go to (B).	<input type="checkbox"/> YES <input type="checkbox"/> NO (Exclude) Go to (B).	<input type="checkbox"/> YES <input type="checkbox"/> NO (Exclude) Go to (B).	<input type="checkbox"/> YES <input type="checkbox"/> NO (Exclude) Go to (B).	<input type="checkbox"/> YES <input type="checkbox"/> NO (Exclude) Go to (B).
(B) (1) Equity: exempt one vehicle, regardless of use. (63-501.523) [If "YES", go to (C). If "NO", go to (B)(2).] (2) Is other vehicle(s) used for job search, employment or training?	<input type="checkbox"/> YES <input type="checkbox"/> NO Go to (C). Use Excess Value.	<input type="checkbox"/> YES <input type="checkbox"/> NO Go to (C) and (D). Use Greater Value.	<input type="checkbox"/> YES <input type="checkbox"/> NO Go to (C). Use Excess Value.	<input type="checkbox"/> YES <input type="checkbox"/> NO Go to (C) and (D). Use Greater Value.	<input type="checkbox"/> YES <input type="checkbox"/> NO Go to (C). Use Excess Value.	<input type="checkbox"/> YES <input type="checkbox"/> NO Go to (C) and (D). Use Greater Value.

(C) Fair Market Values-CA

FMV			
Minus	Minus \$4,650	Minus \$4,650	Minus \$4,650
Excess Value			

(D) Equity Values-CA

FMV			
Minus Encumbrance			
Equity Value			

MEDI-CAL

	(1)	(2)	(3)
DMV/YR/Class Code	_____	_____	_____
Vehicle Market Value	\$ _____	\$ _____	\$ _____
Less Encumbrances	\$ _____	\$ _____	\$ _____
Net Value	\$ _____	\$ _____	\$ _____
Exempt	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Pickle Program (Ref. Sec. 9 in Pickle Handbook):

	(1)	(2)	(3)
Is vehicle used:	Exempt	Yes No	Yes No
As a home			
For self-employment			
To Go to Work or Medical Appointment			

TOTALS: VEHICLE CA

Excess Value \$ _____

Equity Value \$ _____

Grand Total Countable Property
(List totals from pages 7, 8, and 9)

Page	CA	FS	MC
(9)	\$ _____	\$ _____	\$ _____
(8)	\$ _____	\$ _____	\$ _____
(7)	\$ _____	\$ _____	\$ _____
Total	\$ _____	\$ _____	\$ _____

CA FS (36) A. Does anyone have any housing costs? ☐ YES ☐ NO
If "YES", complete below:

HOUSING COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Rent	\$	\$	\$	
House (mortgage) payment	\$	\$	\$	
Property taxes (if not in house payment)	\$	\$	\$	
Insurance (if not in house payment)	\$	\$	\$	
Other (explain)	\$	\$	\$	

CA FS B. Does anyone else pay all or part of these housing costs? Include a relative or friend not living in the home, any rental assistance programs, such as HUD, Section 8, etc. If "YES", complete below: ☐ YES ☐ NO

TYPE OF HOUSING COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED
		\$	
		\$	

COUNTY USE ONLYHousing verified: ☐ YES ☐ NO

Total housing: \$ _____

Shared housing: ☐ YES ☐ NO

FS (37) A. Does anyone have any utility costs? ☐ YES ☐ NO
If "YES", complete below:

UTILITY COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Gas or other fuel	\$	\$	\$	
Electricity or other fuel	\$	\$	\$	
Is the gas or electricity or other fuel used to heat or cool your house?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Water	\$	\$	\$	
Sewer	\$	\$	\$	
Garbage or trash	\$	\$	\$	
Telephone (basic rate for one phone plus tax)	\$	\$	\$	
Installation of utilities	\$	\$	\$	
Other (explain)	\$	\$	\$	

Utilities verified: ☐ YES ☐ NOMetered: ☐ YES ☐ NO

Client elects

☐ Actual

If Actual, Total Utilities

\$ _____

Utility allowance - Prorated

☐ SUA ☐ YES ☐ NO☐ LUA ☐ YES ☐ NO☐ TUA ☐ YES ☐ NO

FS B. Does anyone else pay all or part of these utility costs? Include a relative/friend not living in the home, Low Income Energy Assistance, etc. If "YES", complete below: ☐ YES ☐ NO

TYPE OF UTILITY COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED
		\$	
		\$	

FS (38) You can authorize someone else in your household or someone outside your household to use your food stamp benefits to buy food for you. If you would like to authorize someone, complete below:

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE
		()

☐ F.S. I.D. Issued

CA 39 MC Did anyone get medical/pregnancy treatment this month or in the three months before this month? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;">NAME OF PERSON RECEIVING CARE</th> <th style="width:20%;">MONTHS OF CARE</th> <th colspan="2" style="width:20%;">PAYMENTS MADE FOR CARE</th> <th colspan="2" style="width:20%;">DO YOU WANT MEDICAL FOR THOSE MONTHS?</th> </tr> <tr> <td></td> <td></td> <td>YES</td> <td>NO</td> <td>YES</td> <td>NO</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>	NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	PAYMENTS MADE FOR CARE		DO YOU WANT MEDICAL FOR THOSE MONTHS?				YES	NO	YES	NO													COUNTY USE ONLY Retroactive Application <input type="checkbox"/> Retro Only <input type="checkbox"/> Retro and Cont. <input type="checkbox"/> MC 210A												
NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	PAYMENTS MADE FOR CARE		DO YOU WANT MEDICAL FOR THOSE MONTHS?																																	
		YES	NO	YES	NO																																
CA 40 FS MC Does anyone have MEDICARE coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:20%;">PERSON COVERED</th> <th style="width:20%;">MEDICARE CLAIM NUMBER</th> <th style="width:10%;">FOR</th> <th colspan="3" style="width:50%;">(✓) HOW MONTHLY PREMIUM IS PAID</th> </tr> <tr> <td></td> <td></td> <td></td> <td>DEDUCTED FROM CHECK</td> <td>OUT OF POCKET</td> <td>OTHER</td> </tr> <tr><td> </td><td> </td><td>Part A</td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>Part B</td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>Part A</td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td>Part B</td><td> </td><td> </td><td> </td></tr> </table>	PERSON COVERED	MEDICARE CLAIM NUMBER	FOR	(✓) HOW MONTHLY PREMIUM IS PAID						DEDUCTED FROM CHECK	OUT OF POCKET	OTHER			Part A						Part B						Part A						Part B				<input type="checkbox"/> MEDICARE referral FS: <input type="checkbox"/> DFA 285-C Gross Premium \$ _____ <input type="checkbox"/> QMB <input type="checkbox"/> SLMB/QI <input type="checkbox"/> QDWI
PERSON COVERED	MEDICARE CLAIM NUMBER	FOR	(✓) HOW MONTHLY PREMIUM IS PAID																																		
			DEDUCTED FROM CHECK	OUT OF POCKET	OTHER																																
		Part A																																			
		Part B																																			
		Part A																																			
		Part B																																			
CA 41 MC Does anyone have health, dental, vision, hospitalization or Long Term Care insurance or health plans, such as Kaiser, Blue Cross, CHAMPUS, etc.? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:25%;">INSURANCE COMPANY</th> <th style="width:25%;">PERSON INSURED</th> <th style="width:15%;">EXPIRATION DATE</th> <th style="width:15%;">PREMIUM AMOUNT</th> <th style="width:20%;">HOW OFTEN PAID</th> </tr> <tr><td> </td><td> </td><td> </td><td>\$</td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td>\$</td><td> </td></tr> </table>	INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID				\$					\$		State Certified LTC Policy: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DHS 6155 Benefits Paid Out \$ _____																					
INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID																																	
			\$																																		
			\$																																		
CA 42 MC Does anyone have any health insurance available from a parent, employer, or absent parent, which has not been applied for? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:25%;">INSURANCE COMPANY</th> <th style="width:25%;">PERSON TO BE INSURED</th> <th style="width:15%;">PREMIUM AMOUNT</th> <th style="width:20%;">HOW OFTEN PAID</th> </tr> <tr><td> </td><td> </td><td>\$</td><td> </td></tr> <tr><td> </td><td> </td><td>\$</td><td> </td></tr> </table>	INSURANCE COMPANY	PERSON TO BE INSURED	PREMIUM AMOUNT	HOW OFTEN PAID			\$				\$		<input type="checkbox"/> DHS 6155																								
INSURANCE COMPANY	PERSON TO BE INSURED	PREMIUM AMOUNT	HOW OFTEN PAID																																		
		\$																																			
		\$																																			
CA 43 MC Is anyone's health insurance expected to end or has it ended within the last 60 days? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:25%;">INSURANCE COMPANY</th> <th style="width:25%;">PERSON INSURED</th> <th style="width:15%;">EXPIRATION DATE</th> <th style="width:15%;">PREMIUM AMOUNT</th> <th style="width:20%;">HOW OFTEN PAID</th> </tr> <tr><td> </td><td> </td><td> </td><td>\$</td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td>\$</td><td> </td></tr> </table>	INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID				\$					\$		<input type="checkbox"/> DHS 6155																					
INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID																																	
			\$																																		
			\$																																		
CA 44 MC Does anyone have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:25%;">NAME OF PERSON</th> <th style="width:30%;">TYPE OF PROBLEM</th> <th style="width:20%;">DATE PROBLEM STARTED</th> <th style="width:25%;">EXPECTED DATE OF RECOVERY</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>	NAME OF PERSON	TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY									<input type="checkbox"/> Third Party Liability																								
NAME OF PERSON	TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY																																		
CA 45 FS A. Does anyone have a medical condition(s) or situation(s) that requires any of the following? Check (✓) each item "YES" or "NO": <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;"></th> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> <th style="width:30%;"></th> <th style="width:10%;">YES</th> <th style="width:10%;">NO</th> </tr> <tr> <td>Special diet—prescribed by a doctor</td> <td></td> <td></td> <td>Very high use of utilities</td> <td></td> <td></td> </tr> <tr> <td>Special transportation need</td> <td></td> <td></td> <td>Special laundry service</td> <td></td> <td></td> </tr> <tr> <td>Special telephone or other equipment</td> <td></td> <td></td> <td>Other (specify):</td> <td></td> <td></td> </tr> <tr> <td>Housework (no one in the home can do it)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> If "YES", explain:		YES	NO		YES	NO	Special diet—prescribed by a doctor			Very high use of utilities			Special transportation need			Special laundry service			Special telephone or other equipment			Other (specify):			Housework (no one in the home can do it)						Verified: <input type="checkbox"/> YES <input type="checkbox"/> NO Special Need: <input type="checkbox"/> YES <input type="checkbox"/> NO Amount: \$ _____						
	YES	NO		YES	NO																																
Special diet—prescribed by a doctor			Very high use of utilities																																		
Special transportation need			Special laundry service																																		
Special telephone or other equipment			Other (specify):																																		
Housework (no one in the home can do it)																																					
CA 45 FS MC B. Is there a child or disabled person in the household who needs care from another household member? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain:																																					
CA 45 MC C. Is anyone a disabled person who is working and who has medical expenses (wheelchair, etc.), which are needed for the person to be able to work? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;">NAME OF PERSON</th> <th style="width:40%;">TYPE OF EXPENSE</th> <th style="width:30%;">AMOUNT</th> </tr> <tr><td> </td><td> </td><td>\$</td></tr> <tr><td> </td><td> </td><td>\$</td></tr> </table>	NAME OF PERSON	TYPE OF EXPENSE	AMOUNT			\$			\$	<input type="checkbox"/> Receipts <input type="checkbox"/> MC 272 <input type="checkbox"/> MC 273 <input type="checkbox"/> IRWE (QMB and SGA) FS: <input type="checkbox"/> DFA 285-C																											
NAME OF PERSON	TYPE OF EXPENSE	AMOUNT																																			
		\$																																			
		\$																																			
CA 45 FS D. Is anyone getting In-Home Supportive Services (IHSS)? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", who gets service? _____ How much do you pay each month? \$ _____																																					

CA (46) Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and unusual circumstances, such as an earthquake, fire, or flood? If "YES", explain below.	<input type="checkbox"/> YES <input type="checkbox"/> NO	COUNTY USE ONLY <table border="1"> <tr> <td data-bbox="1198 138 1453 170">Special Need Verified</td> <td data-bbox="1453 117 1560 138">YES</td> <td data-bbox="1453 138 1560 170">NO</td> </tr> <tr> <td data-bbox="1198 170 1453 201">Eligible for Special Need</td> <td data-bbox="1453 170 1560 201"></td> <td data-bbox="1453 201 1560 254"></td> </tr> </table>		Special Need Verified	YES	NO	Eligible for Special Need																
Special Need Verified	YES	NO																					
Eligible for Special Need																							
CA (47) Is any member of the household avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole? If "YES", give name of the person:	<input type="checkbox"/> YES <input type="checkbox"/> NO																						
CA (48) Have you or any member of your household been convicted of a drug-related felony? If No, go to question 49. If Yes, Name: _____ Date convicted: _____. Was the conviction for any of the following: <ul style="list-style-type: none"> Transporting, importing into this state, selling, furnishing, administering, giving away, possessing for sale, purchasing for the purposes of sale, manufacturing, or processing precursors with the intent to manufacture a controlled substance or cultivating, harvesting, or processing marijuana? <input type="checkbox"/> YES <input type="checkbox"/> NO Encouraging, inducing, soliciting or intimidating a minor to participate in any of the above activities? <input type="checkbox"/> YES <input type="checkbox"/> NO Have you or any member of your household: <ul style="list-style-type: none"> a) Completed a government recognized drug treatment program? <input type="checkbox"/> YES <input type="checkbox"/> NO b) Participated in a government recognized drug treatment program? <input type="checkbox"/> YES <input type="checkbox"/> NO c) Enrolled in a government recognized drug treatment program? <input type="checkbox"/> YES <input type="checkbox"/> NO d) Been placed on a waiting list for a government recognized drug treatment program? <input type="checkbox"/> YES <input type="checkbox"/> NO e) Ceased the use of controlled substances and have evidence that you have ceased? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, please explain: _____		FS convictions after 8/22/96 CW convictions after 1/1/98 Qualifying Drug Felon? <input type="checkbox"/> Yes <input type="checkbox"/> No Meets felony conditions of eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
CA (49) The following services are available. Your answers to these questions will not affect your eligibility. Check (✓) each item "YES" or "NO." A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21. <ul style="list-style-type: none"> Do you want more information about CHDP Services? Do you want CHDP medical services? Do you want CHDP dental services? Do you need help making appointments or with transportation to CHDP services? B. Do you want more information about immunization services?..... C. If you are pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help? D. Are you breastfeeding a child? If "YES", have you given birth within the last 12 months? If you checked "YES" to (49) C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC). E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unplanned pregnancies and/or have the next child? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.	<table border="1"> <tr> <th>YES</th> <th>NO</th> </tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>	YES	NO																				<input type="checkbox"/> CHDP Brochure and Explanation Given Date: _____ <input type="checkbox"/> CHDP Referral <input type="checkbox"/> Social Services Referral (MCO) <input type="checkbox"/> Referred for Immuniz. <input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5 <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum <input type="checkbox"/> WIC referral <input type="checkbox"/> Family Planning Information Given <input type="checkbox"/> Referred Date:
YES	NO																						

CERTIFICATION

I understand that:

- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, school attendance, etc. And for cash aid and food stamps, records will be matched with law enforcement agencies for arrest warrants.
- All facts, including benefit and income facts, I gave may be reviewed and checked out by county, state, and federal personnel, and that if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the U.S. Citizenship and Immigration Services (USCIS) (Formerly INS) to verify immigration status and the facts the county gets from USCIS may affect my eligibility for cash aid, food stamps, and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am not (a) a lawful permanent resident noncitizen (LPR), (b) an amnesty alien with a valid and current I-688, or (c) a noncitizen permanently residing in the United States under color of law (PRUCOL), the county will not send facts to the USCIS.
- I must apply for and keep any available health coverage if no cost is involved; if I do not my Medi-Cal will be denied or stopped.
- I or other family members will be required to repay any cash aid I should not have received.
- The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a noncitizen household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.
- Any member of my household who is avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of their parole or probation cannot get cash aid or food stamps.
- Any household member who has been convicted after August 22, 1996 of a drug-related felony for possession, use, manufacturing, sale, distribution of a controlled substance, or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in the above activities, cannot receive food stamp benefits.
- For cash aid and food stamp benefits, the county will require that I and certain household members be fingerprint and photo imaged. My benefits may be denied or stopped if I do not cooperate.

I also understand that:

I will get disqualification and/or welfare fraud penalties if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

For cash aid:

- If I on purpose do not follow cash aid rules, I may be fined up to \$10,000 and/or sent to jail/prison for 3 years. And my cash aid can be stopped:
 - For not reporting all facts or for giving wrong facts: 6 months for the first offense, 12 months for the second, or forever for the third; and for Refugee Cash Assistance, 3 months for the first and 6 months for any later offense.
 - For submitting one or more applications to get aid in more than one case at the same time: 2 years for the first conviction, 4 years for the second, or forever for the third.
 - For conviction of felony thefts to get aid: 2 years for theft of amounts under \$2000; 5 years for amounts of \$2000 through \$4999.99; and forever for amounts of \$5000 or more.
 - For giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county false proof for an ineligible child or a child that does not exist; getting more than \$10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing: forever.

For food stamps:

- If on purpose I do not follow food stamp rules, my food stamps will be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to \$250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
 - I traded or sold food stamp benefits for firearms, ammunition, or explosives, my food stamp benefits can be stopped forever for the first violation.
 - I traded or sold food stamp benefits for controlled substances, my food stamp benefits can be stopped for 24 months for the first violation and forever for the second.
 - I traded or sold food stamp benefits that were worth \$500 or more, my food stamp benefits can be stopped forever.
 - I filed two or more applications for food stamp benefits at the same time and gave the county false identity or residence information, my food stamp benefits can be stopped for 10 years.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, MEDI-CAL APPLICANT, ADULT FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMP AUTHORIZED REPRESENTATIVE)		DATE	
SIGNATURE (OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)	DATE	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY	DATE

COUNTY USE ONLY																				
ELIGIBILITY FACTORS REVIEWED						ELIGIBILITY FACTORS REVIEWED						FOOD STAMP TESTS								
		CA		FS		MC				CA		FS		MC				YES	NO	NA
		YES	NO	YES	NO	YES	NO			YES	NO	YES	NO	YES	NO					
Residency								Property/Resources—Within limits									Gross Income Test			
Deprivation																	Household Size			
Age								Work participation									Gross Monthly Income \$			
Immunizations								FSET									Gross Income Eligible			
Citizen/Eligible noncitizen								ABAWDs									Separate HH Income Test			
School enrollment								CFAP									Household Size			
Pregnancy verif./ WIC Referral								Sponsored noncitizen									Gross Monthly Income \$			
SSN								Federal participation established (If "NO", explain)									Eligible for Separate HH Status			
Income—Applicant/Recipient test(s)								Referred for Health Care Options (HCO) Presentation									Aged/Disabled			
SFIS																	DFA 285-C			
TANF Time Limits																				
CalWORKs Time Limits																				

COMMENTS

AU Size:		Non-AU Size:		AU/MFBU Size:	
<input type="checkbox"/> INELIGIBLE (REASON)					
<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> REDETERMINATION		<input type="checkbox"/> DIVERSION <input type="checkbox"/> EXEMPT MAP		AUTHORIZATION DATE	
ELIGIBILITY CONDITIONS MET (DATE):				EFFECTIVE DATE	
WORKER'S SIGNATURE				DATE	
SUPERVISOR'S SIGNATURE (COUNTY OPTION)				DATE	

FS:		HH Size:	
<input type="checkbox"/> INELIGIBLE (REASON)			
<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> RECERTIFICATION		AUTHORIZATION DATE	
WORKER'S SIGNATURE		DATE	
SUPERVISOR'S SIGNATURE (COUNTY OPTION)		DATE	



RIGHTS, RESPONSIBILITIES AND OTHER IMPORTANT INFORMATION

For the Cash Aid and Food Stamp Programs, and/or Medi-Cal/34-County Medical Services Program (CMSP)

These pages give you your rights and responsibilities and other important information. The county needs your facts to see if you are eligible for cash aid, food stamps, and/or Medi-Cal/34-County CMSP and to figure how much you will get if you are eligible. If you need more information or have questions, ask your worker.

Cash Aid includes California Work Opportunity and Responsibility to Kids (CalWORKs) and Refugee Cash Assistance (RCA).

Medi-Cal/34-County CMSP includes Full Medi-Cal/34-County CMSP benefits and Restricted Medi-Cal/34-County CMSP emergency and pregnancy related care only.

YOUR RIGHTS

1. To be treated equally without regard to race, color, national origin, religion, political affiliation, marital status, sex, disability, or age. You may file a complaint of discrimination if you feel you have been discriminated against by first speaking with your county's designated civil rights representative or by writing to the

State Civil Rights Bureau
744 P Street, MS 15-70
P.O. Box 944243
Sacramento, CA 94244-2430

or by calling toll free 1-866-741-6241 or for the hearing impaired TDD 1-800-688-4486.

2. To get help applying for or continuing to receive cash aid, benefits and services if you have a disability. If you need help because of a disability, tell the county.
3. To ask for help to complete your application for any other cash aid, food stamp, or Medi-Cal/34-County CMSP form.
4. To ask for an interpreter and to have forms and notices translated if you don't speak or read English.
5. To be treated with courtesy, consideration and respect.
6. To be interviewed promptly by the county when you apply and to have your eligibility determined within 45 days for cash aid and Medi-Cal/34-County CMSP (or 90 days for Medi-Cal if a determination of disability is required) and within 30 days for food stamps.
7. To discuss your case with the county and to review your case yourself when you request to do so.
8. To be told the rules for getting cash aid right away. If we think you might be eligible, you will get an interview within one day.
9. To be told the rules for getting food stamps right away. If we think you might be eligible to get them right away, you will get an interview immediately and get food stamps within three days.
10. To get Medi-Cal/34-County CMSP as soon as possible if you have a medical emergency or are pregnant, if eligible.
11. To continue getting cash aid and Medi-Cal benefits without a break if you move from one county to another if you stay eligible.
12. To be told the rules for retroactive Medi-Cal eligibility.
13. To lower any current Share of Cost you may have by giving the county past unpaid medical bills you still owe, when you apply for Medi-Cal/34-County CMSP.

14. To choose prepaid health plan (PHP), fee-for-service coverage (if available), Health Maintenance Organization (HMO), or Medi-Cal when eligible for Medi-Cal.
15. To ask to have your Food Stamp I.D. or Medi-Cal Benefits Identification Card (BIC), or EBT card replaced if lost in the mail, damaged, or destroyed. The county will tell you if you are eligible.
16. To ask for extra money if your income drops or stops (cash aid only).
17. To ask for payments for clothing, housing or essential household items which are lost, damaged or otherwise unavailable due to sudden and unusual circumstances (cash aid only).
18. To ask for payments for ongoing special needs like a special diet, transportation for ongoing medical care, special laundry service, telephone for the hard of hearing, high utility bills, etc. (cash aid only).
19. To be notified in writing when your application is approved, denied, or when your benefits change or stop.
20. To have your records kept confidential by the county and state, unless you are getting cash aid or food stamps and there is a felony arrest warrant issued for you, or as otherwise provided by law.
21. To talk with someone from the county or file a formal complaint with the state if you don't agree with an action taken by the county. You may call toll-free at 1-800-952-5253 or for the hearing impaired, TDD 1-800-952-8349.
22. To ask for a State Hearing within 90 days of the county's action for cash aid, food stamps and Medi-Cal.
23. To ask for a State Hearing, you can write to your county or call the State toll-free telephone numbers listed in Item 21 above.
24. To appeal all 34-County CMSP eligibility issues, you can **only write** to your county.
25. To be represented at a State hearing by yourself, a household member, friend, attorney, or other person of your choice. NOTE: You may get free legal help at your local legal aid office or welfare rights group.

YOUR RESPONSIBILITIES

Citizenship/Immigration Status

To sign under penalty of perjury that each member applying for cash aid and food stamps is a U.S. citizen, U.S. national or has lawful immigration status. Information you give us on immigration status will be checked with the U.S. Citizenship and Immigration Services (USCIS). Information we get from USCIS may affect your eligibility. (Manual of Policies and Procedures Section 42-433).

If you want Medi-Cal/34-County CMSP, you must provide a declaration of citizenship/immigration status under penalty of perjury. If you say you are a noncitizen with lawful permanent residence (LPR) in the U.S., an amnesty alien with a valid and current I-688 or a noncitizen permanently residing under color of law (PRUCOL), your immigration status will be checked with the USCIS. The information the USCIS receives to verify the immigration status of the applicant can only be used to determine Medi-Cal/34-County CMSP eligibility, and cannot be used for immigration enforcement unless you are committing fraud.

Fingerprint/Photo Imaging

All eligible adult household members for cash aid and/or food stamps must be fingerprint/photo imaged. If anyone who is required to cooperate with these rules does not get fingerprint/photo imaged, no benefits will be issued to the entire household. (Manual of Policies and Procedures Section 40-105.3).

The fingerprint/photo images are confidential and can only be used to prevent or prosecute welfare fraud.

Social Security Number (SSN) Rules

The SSNs will be used in a computer match to check income and resources with records from tax, welfare, employment, the Social Security Administration and other agencies. Differences may be checked out with employers, banks or others. Making false statements or failing to report all facts or situations which affect eligibility and aid payments for cash aid, food stamp and Medi-Cal/34-County CMSP may result in repayment of benefits and/or criminal or civil action.

Cash Aid and Food Stamps: You must give us the SSN for each applicant or recipient of cash aid and/or food stamps. If you refuse to give us either a SSN or proof of application for a SSN, you will not be able to get cash aid or food stamps. For cash aid, you must give proof of application for a SSN within 30 days of application for cash aid and give the SSN to the county when you get it. (Manual of Policies and Procedures Section 40-105.2).

Each applicant for Medi-Cal/34-County CMSP, who says he/she is a U.S. citizen, a U.S. national, LPR in the U.S., an amnesty alien with a valid and current I-688, or PRUCOL, will be disqualified from getting Medi-Cal if he/she refuses to give either a SSN or proof of application for a SSN. Any noncitizen who does not have a SSN and who is not an amnesty alien with a valid and current I-688 or a LPR or PRUCOL, can still get restricted Medi-Cal/34-County CMSP if he/she meets all eligibility rules, including California residency.

Verification(s)

To give proof to support your eligibility. If you can't get proof, you will need to give the name of some other person or agency we may contact to get the proof. We will help you get proof when you can't get it. (Manual of Policies and Procedures Sections 40-105.1; 40-157.212; 40-157.213)

Cooperation

To cooperate with county, state and federal staff. For cash aid, a county worker can come to your home at an arranged time to check out your facts, including seeing each family member. You may not get benefits or your benefits may be stopped if you don't cooperate.

CASH AID AND MEDI-CAL

To apply for any benefits or income anyone is eligible to get, such as: Unemployment (UIB) or Disability benefits, Veterans benefits, Social Security or Medicare, etc.

Child/Spousal and Medical Support

To cooperate with the county and the Local Child Support Agency to:

- identify and locate any absent parent in your case;
- tell the county or the Local Child Support Agency anytime you get information about the absent parent, such as place of residence or work location;
- determine the paternity of any child in your case when needed;
- obtain medical support money from any absent parent and, if you get cash aid, obtain child support money;
- give the Local Child Support Agency any medical support money and, any child/spousal support money you get;
- tell the county about medical coverage or money for medical services paid by the absent parent.

Your cash aid will be lowered if you don't cooperate. (Manual of Policies and Procedures Sections 40-157.212; 40-157.213).

MEDI-CAL

Benefits Identification Card (BIC)

- To sign your BIC when you get it and to use it only to get necessary health care services.
- **To never throw your BIC away** (unless we give you a new BIC). You need to keep your BIC even if you stop getting Medi-Cal. You can use the same BIC if you get cash aid or Medi-Cal again.
- To take the BIC to your medical provider when you or a family member is sick or has an appointment.
- To take the BIC to the medical provider who treated you or your family member(s) in an emergency situation as soon as possible after the emergency.

Health Care Coverage/Insurance

- To tell the county and any health care provider of any health care coverage/insurance you or a family member have.
- To retain any health insurance available to you and your family at no or reasonable cost.
- To use any prepaid health plans, health maintenance organization or health care insurance plans you have before using Medi-Cal/34-County CMSP, unless the plan does not offer the medical service needed. You need to use them because Medi-Cal will not pay for any service paid for and/or provided by these medical insurance plans.
- To enroll and stay enrolled in an employment-related group health plan when Medi-Cal approves payment of plan premiums by the State of California.

YOUR REPORTING RESPONSIBILITIES

You must report certain information to the county. If you're not sure how to report, what to report, or what proof we need, ask your worker. If you get food stamps, your worker will tell you if you are a quarterly or change reporting household. If you get Medi-Cal/34-County CMSP, the county will tell you when you must report. (Manual of Policies and Procedures Section 40-181).

HOW YOU MUST REPORT

For Cash Aid and Food Stamp Quarterly Reporting, you must turn in a Quarterly Eligibility Report (QR 7) by the fifth day of the month following your report months and report all required changes to the County within 10 days.

For Food Stamp Change Reporting, you must report all changes within 10 days:

- by mail, telephone, or in person at the County Food Stamp office; OR
- on a DFA 377.5, Food Stamp Household Change Report

For Medi-Cal, you must report all changes within 10 days AND turn in a complete Status Report by the 5th of the month when the county sends or gives it to you.

WHEN YOU MUST REPORT

For Cash Aid and Food Stamp Quarterly Reporting

Quarterly reporting rules say that you must report things at certain times. You will be assigned a "report month" for each quarter (three month period). This will be the second month of each quarter. For example, if your quarter is January, February and March, February would be your "report month" and your report would be due by the 5th day of March. The report is always due by the 5th day of the month following your "report month" and will be considered late if not received by the 11th day of the month. If your Quarterly Eligibility Report (QR 7) is late you will have to pay back any Cash Aid or Food Stamps that you were not supposed to get. You will have to report gross income, changes in the number of people in your household, property bought or sold by people in your household and other information for that report month as well as any changes in your gross income that you expect to happen in the next quarter. If you do not turn in a completed Quarterly Eligibility Report (QR 7) by the end of the first working day of the month after the month your report is due, your household's benefits will be stopped.

What you must report on the Quarterly Report:

1. **Earned Income:** All gross earned income received by you or anyone in your household in the report month. This includes wages; tips; vacation pay; cash bonuses; money from self employment or from a training program; also any income in kind in exchange for work, such as free rent, clothing or food.

2. **Unearned or Disability Based Income:** All other income received by you or anyone in your household in the report month. This includes Child/spousal support; interest or dividends; gambling/lottery winnings; insurance or legal settlements; strike benefits; cash, gifts, loans scholarships; tax refunds; any government benefits, like Social Security, Supplemental Security Income/State Supplementary Payment (SSI/SSP), unemployment, worker's compensation, state disability indemnity, veterans or railroad retirement, or other private or government disability or retirement; rental income and rental assistance; free housing/utilities/clothing/food; or any other type of money received.
3. You must also report on your Quarterly Report any changes in income that you expect to happen during the next quarter. This includes earned, unearned and disability based income changes.
4. **Property:** Any property including, motor vehicles; bank accounts; savings bonds; insurance policies; a home or land; trust; EBT cash balance, etc. that you or anyone in your household has received since your last Quarterly Report and still has, whether it was bought, obtained through a trade or as a gift. The county will use this information to determine if your household exceeds the property limit. You must also report if you or anyone sold, traded or gave away any property since your last Quarterly Report.
5. **If You Move or Someone Moves Into or Out of Your Home:** Anyone (including newborns) who moved into your home since your last Quarterly Report and is still there. You must also report anyone who moved out of your home or who has died since your last Quarterly Report.
6. **Convicted Drug Felons, Fleeing Felons and Probation/ Parole Violators:** The name of anyone in your household who is either avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole. You must also report any household member who has been convicted of a drug felony for possession, use, manufacturing sale or distribution, of a controlled substance, or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in these activities. For food stamps you must report felonies since August 22, 1996 and for Cash Aid list convictions that happened after January 1, 1998.
7. **Reduced Hours of Work:** If you are an Able-Bodied Adult Without Dependents (ABAWD), you must report when your hours of work drop below 20 hours a week or 80 hours a month. You must also report if you expect your work hours to drop below these limits during the next three months.

For Medi-Cal/34-County CMSP, you must report when:

1. Anyone enters or leaves a nursing home or long term care facility.
2. Anyone applies for disability benefits, such as SSI/SSP, Social Security, Veterans, or Railroad Retirement.
3. Anyone gets health care services that result from an accident or injury due to someone else's action or failure to act.

YOUR REPORTING RESPONSIBILITIES (CONTINUED)

For Non-Assistance Food Stamps Quarterly Reporting

If you only get Food Stamps you must report when:

1. Anyone in the household moves to another address, plans to move or gets a new mailing address.
2. Anyone who is an Able Bodied Adult Without Dependents (ABAWD) Food Stamp recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.

For CalWORKs you must report certain changes at other times:

In certain circumstances you will be required to report things (within ten days of the change) even if it is not your "report month" such as:

1. Anytime that your family's combined gross income (both earned and unearned) is more than the Income Reporting Threshold (IRT) for a family of your size. Your county worker will tell you the IRT limit for a family of your size. If your family only gets unearned income or only gets Food Stamps, you will only be required to report income on your Quarterly Eligibility Report (QR 7).
2. Anytime that someone in your household is convicted of a drug related felony, becomes a fleeing felon or is in violation of probation or parole.
3. Anytime you move you must report your address change so that the County will know where to send your benefits, Quarterly Report forms and notices.

Reporting information voluntarily for CalWORKs and Food Stamps Quarterly Reporting:

You may also report other information voluntarily even when it is not your "report month." Reporting information voluntarily may cause your household's benefits to go up. If the information reported causes your benefits to go up, the county will take action within ten days after you provide verification. One exception is when the increase results from adding another person to your case. In that situation, the County will take action to increase benefits the first of the month after you provide verification. Even if you have already reported something to the County, you must also report it on your next Quarterly Report (QR 7).

Some examples of voluntary reporting that may cause your benefits to go up include:

- Your income stops or drops.
- Someone who has little or no income moves into your home (including a newborn).
- Someone who has income moves out of your home.
- You believe that you or someone in your household is eligible for a CalWORKs Special Needs payment, such as pregnancy special needs or a qualifying special diet.

Additional examples for Food Stamps only:

- A household member begins to pay court ordered child support for a child not living in the home.
- A household member is 60 or older.
- Any member who is disabled or 60 years of age or older has changes in or new medical expenses (if verified your Food Stamps can be refueled).

Additional Information for Food Stamp Only Households

If you receive food stamp benefits and you voluntarily report income that has increased, and it is above the gross income level for your household size, your benefits may be discontinued.

Note that if you receive only food stamp benefits: (1) you do not have to report any increases in income during the quarter; and, (2) when you report changes to the county or in between written quarterly reports, you must also report the change on your next QR 7.

At anytime you can ask the County to discontinue your entire case or any individual person who has left the home or is not required to be in the assistance unit. You can also ask the County to discontinue certain benefits, such as: Medi-Cal or Food Stamps. Receiving Medi-Cal/or Food Stamps only will not count against your Cash Aid time limits.

Other changes for quarterly reporting:

There are other changes that will cause the County to decrease or discontinue your benefits during the quarter in which they happen. Here are some examples:

- An adult in the household reaches the CalWORKs 60-month time limit;
- A household member is sanctioned/penalized;
- A child reaches the age of 18 (and will not graduate from high school before the age of 19);
- Someone in your household begins receiving benefits in another household;
- An eligible child is placed in Foster Care;
- Anyone who is an Able Bodied Adult Without Dependents (ABAWD) Food Stamp recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.

FOOD STAMP CHANGE REPORTING

For Food Stamp Change Reporting, you must report when:

1. Your total monthly income starts, stops, or changes by more than \$50.
2. Anyone's source of income changes.
3. Anyone moves into or out of your home.
4. Anyone joins or leaves your household.
5. You move or you get a new address.
6. Your rent and utility costs **only** if you move.
7. Anyone buys, gets, sells, or gives away a licensed motor vehicle.
8. The total of your household's stocks, bonds, or other money is or is more than \$2000 (or \$3000 if you have a household member who is age 60 or older).
9. If there is a change in the amount of any court ordered child support paid by a member of the household for a child not living in the home.
10. Anyone who is an Able Bodied Adult Without Dependents (ABAWD) Food Stamp recipient and the number of hours they work or are in training drop to less than 20 hours a week or 80 hours a month.
11. Any member of your household is avoiding or running from the law to avoid any felony prosecution, custody or confinement after conviction, or is in violation of probation or parole.
12. Any household member convicted of a drug-related felony after August 22, 1996, for manufacturing, sale or distribution of a controlled substance(s), or any activity in connection with these unlawful acts, or harvesting, cultivating or processing marijuana, or involving a minor in the above activities.

For Food Stamp Change Reporting, you may report when:

1. Anyone's physical or mental illness begins or ends.
2. Anyone's citizenship/immigration status changes or anyone gets a letter, form or new card from the USCIS.
3. You have changes in your dependent care costs.
4. Any member who is disabled or age 60 or older has changes in or new medical expenses. If verified, your allotment can be refueled.
5. Any household member starts to pay court ordered child support for a child not living in the home.

YOUR REPORTING RESPONSIBILITIES (CONTINUED)

IMPORTANT INFORMATION CASH AID ONLY

Unemployed Parent

If you are applying for cash aid as an unemployed parent, the principal earner (PE) must:

- be unemployed and not have worked in the preceding 4 weeks
- apply for and accept any unemployment insurance you are eligible to receive

The PE is the parent who has the most earnings in the past 24 months.

Homeless Assistance

You may be eligible for money to help pay for temporary shelter, permanent housing or to prevent eviction. This is a once-in-a-lifetime payment unless you meet an exemption. If you have already received homeless assistance and need it again, your worker will tell you if you are eligible.

School Attendance and Immunizations

You must provide proof when requested by the county that:

- all school-age children are attending school, and
- children under the age of 6 have received age appropriate immunizations. (Manual of Policies and Procedures Sections 40-105.4; 40-105.5).

Maximum Aid Payment (MAP)

There are two levels of Maximum Aid Payment (MAP). Most families getting cash aid get the lower MAP level. Families may get the higher MAP level if each parent or caretaker in the Assistance Unit (AU):

- is disabled and getting Supplemental Security Income/ State Supplemental Payments (SSI/SSP), or In-Home Supportive Services (IHSS), or State Disability Insurance (SDI), or Temporary Workers Compensation (TWC), or Temporary Disability Indemnity (TDI) benefits
- is caring for an aided child(ren) who is not their child and the caretaker does not get cash aid.

Also eligible for the higher MAP:

- a family who gets Refugee Cash Assistance (RCA) if each adult meets an exception.

If all the adults in the household meet at least one of these exemptions, ask your worker about applying for an exemption.

Treatment of Self-Employment

If you are self-employed, you will have a choice of figuring your business expenses based on a standard deduction of 40 percent of gross income or using actual business expenses. Once you choose a method of figuring your self-employed net income, you can only change that way of figuring expenses at redetermination or every six months whichever happens sooner.

Maximum Family Grant (MFG) Rule

The MFG rule applies to any child born after August 31, 1997. The MFG rule says that your maximum aid payment (MAP) will not go up to include a child born to your family, if your family got cash aid for the 10 months in a row right before the child's birth. There are exemptions to the rule. Your worker will give you a copy of the MFG rules and answer your questions. Then you will sign a copy that says you understand the rules.

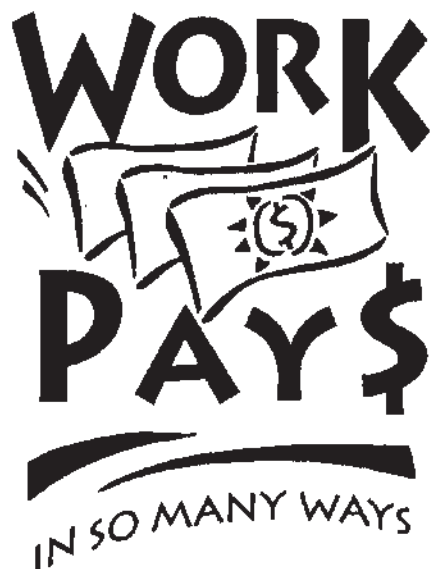
Proof of Facts

If you ask for cash aid within one year of the date it stopped, the county must look at your prior case file to see if it already has the proof needed to determine your eligibility when:

- you cannot get the proof, or
- there is a cost to you to get the proof, or
- processing your application would be delayed because it would take too long for you to get the proof.

If you ask for cash aid within one year of the date it stopped AND, if the county doesn't have the proof it needs, then you will have to provide proof.

If you have new changes since you last got cash aid, the county will need new proof.



Here's how **Work Pays**:

- Gives you more \$\$\$\$ to help support your family
- Builds a better life for you and your family
- Develops job skills
- Builds self-esteem
- Gives you personal satisfaction

You can work and still get cash aid:

- ✓ In most cases, when you work, your gross earnings (earnings before deductions) are not subtracted dollar for dollar from your cash aid payment. You may be eligible for **work related deductions**. When you add it up, you have more \$\$\$\$ for your family.
- ✓ When you have a **grant-based on the job training (OJT)** assignment, all or part of your cash aid payment is used by your employer to help pay your wages. You do not get work related deductions for grant based OJT wages.
- ✓ Either way, you may be eligible for child care costs that are paid to your provider.

See page 7 for facts about work and training rules, work incentives, including child care programs. Ask your worker for more facts about **Work Pays** and how **grant-based OJT** can work for you.

Remember, you can work and still get cash aid as long as you stay eligible and meet reporting rules in a timely manner.

Work and Training Rules

Your worker will tell you what cash aid and/or food stamp work rules you need to follow before and after your application is approved. You may be required to be in work, training or education activities to keep getting your cash aid, food stamps, or both. More than one member of a household can be required to follow cash aid and/or food stamp work rules. If anyone becomes ineligible for not following work or training rules, other members of their household can still get cash aid or food stamps, as long as they remain eligible. But, the amount of cash aid or food stamps they get may change.

Cash Aid Work Rules

If you get cash aid and food stamps or just get cash aid, you will need to take part in certain Welfare-to-Work activities to keep getting your cash aid and food stamps. The county will tell you how many hours a week you must take part in these activities or if you are excused from these rules. Welfare-to-Work activities include, but are not limited to, subsidized or unsubsidized work, work experience, community service, adult basic education, vocational training, and job search. Subsidized means that the county or some other funding source pays your employer for part of your wages.

The cash aid work rules also say you must:

- Sign a Welfare-to-Work plan;
- Take a suitable job that is offered to you;
- Not quit a job or reduce your earnings.

Sanctions for Not Meeting Cash Aid Work Rules

Any time you don't meet cash aid work rules for a good reason, your cash aid will be stopped until you do what you should do. After your cash aid is stopped or reduced, you can only get it back again if you meet the work rules that you had stopped meeting or you become excused. If your cash aid is stopped, your food stamps may also be stopped or reduced.

Food Stamp Work Rules for Persons Not Receiving Cash Aid

If you only get food stamps, you may need to take part in certain employment and training activities to keep getting your food stamps. These activities include job search, workfare, adult basic education, and vocational training. The county will tell you how many hours a week you must take part in these activities or if you are excused from these rules.

The food stamp work rules also say you must:

- Answer questions about your job experience and ability to work;
- Check on a possible job we tell you about and take a suitable job that is offered to you;
- Not quit a job or reduce the number of hours you work to less than 30 hours per week.

Food Stamp Only Penalties

If you don't meet food stamp work rules and you don't have a good reason, your food stamps will be denied or stopped for one, three, or six months, depending on the number of times you stop meeting the rules. After your food stamps are stopped, you can only get them again at the end of the penalty or sooner if you become excused.

Work Requirement for Able-Bodied Adults Not Receiving Cash Aid

If you only receive food stamps and you don't have minor children, there is another work rule which you also may need to meet. You do not have to meet this work rule if you are under age 18, over age 49, pregnant, or you are part of a food stamp household with a minor child. You may be excused for other reasons that your county worker can explain. The work rule says that if you are an able-bodied adult, you must work at least 20 hours a week or 80 hours a month in paid employment, take part in a workfare project for the required number of hours, or take part in an approved training activity for at least 20 hours per week or 80 hours per month. During a period of 36 months, food stamps will stop if there are three months in which you do not meet the work rule. If you stop meeting the work rule a second time for reasons such as being laid off, you may be able to get food stamps for three months in a row without having to meet the rule. After that you can only get food stamps if you meet the work rule or get excused.

Income Disregards

When you have income and are on cash aid, there are two income disregards (deductions) that may be subtracted from certain types of family income. When you or any of your family members receive certain types of disability-based unearned income or you are working and getting cash aid, you are eligible for an income disregard of \$225. The \$225 is first deducted from certain disability-based unearned income. Any remainder of the \$225 is then deducted from earned income. If there is a remainder of earned income, 50 percent of that remaining earned income will be disregarded.

Treatment of Self-Employment

If you are self-employed, you will have a choice of figuring your business expenses based on a standard deduction of 40 percent of gross income or using actual business expenses. Once you choose a method of figuring your self-employed net income, you can only change that way of figuring expenses at redetermination or every six months whichever happens sooner.

CalWORKs Child Care Program

Child care benefits are available to recipients who need child care to work or participate in county-approved welfare-to-work activities such as attending education or job training programs.

California Department of Education (CDE) Child Care

Child care benefits are also available from CDE. Contact your local Resource and Referral Agency for more information.

Transitional Medi-Cal (TMC)

You may get Medi-Cal for up to 24 months if you go off cash aid because you are working. Your family must have gotten cash aid for at least three of the last six months before cash aid stopped. To get more than six months of TMC, your income must be under certain limits and you must meet TMC reporting rules.

OTHER IMPORTANT INFORMATION

CASH AID AND FOOD STAMP QUARTERLY REPORTING HOUSEHOLDS Budgeting Rules

The amount of cash aid and/or food stamps you can get depends on your income and allowable expenses. You will get a Quarterly Eligibility Report (QR 7) to fill out every three months. On the QR 7, you will need to report what income and expenses you had in the last month and what income and expenses you think you will have in the three months after you turn in your report. The income and expenses you expect to have in the next three months will be used to figure the amount of cash aid and/or food stamps you can get for those three months. Information that you put on the QR 7 about the past month will be used for the next three months if you don't expect your income or expenses to change.

For example, if you turn in a QR 7 in March, you will report what income you had in February. You will also report any income changes you expect to have in April, May and June. If the income from February will stay the same, your cash aid and/or food stamps for April, May, and June will be figured using that same income and expenses for each of those months. If your income and expenses will change, your worker will use the new income amounts you think you'll get in April, May, and June to figure your cash aid and/or food stamp amount for those months. This method is called prospective budgeting.

Property Limit

There is a \$2000.00 limit on the amount of property (e.g., bank accounts, stocks, etc.) that your household can have and still get cash aid or food stamps. If someone in your household is at least 60 years old, the limit goes up to \$3000.00. Your house and furniture are not part of the total limit as long as you live in your home. The individual vehicle value limit is \$4650. If your registered vehicle is worth more than \$4650, anything over the limit will be used as part of the total property limit unless the vehicle is needed by the household for certain reasons. Ask your worker what the reasons are. Any vehicle you have, that cannot be sold for more than \$1500, will not be used as part of the total property limit to determine eligibility. Your worker can tell you how to figure the value of any unregistered vehicles.

CASH AID ONLY

60-Month Time Limit

As of January 1, 1998, a parent or caretaker relative is not eligible for cash aid when he/she has received cash aid for a total of 60 months. All aid received through CalWORKs (California Work Opportunity and Responsibility to Kids) and/or cash aid received from any other state counts toward the 60-month total. Only cash aid received on or after January 1, 1998, counts toward the 60-month total. There are exceptions to this time limit and the limit does not apply to children.

Resources/Electronic Benefits Transfer (EBT)

Any balance remaining in the EBT account at the end of the month will be considered an available resource and could make your household ineligible for cash aid if your total countable resources are more than the allowable resource limits.

Transfer of Assets Rule

Recipients can sell, exchange or change the form of their property holdings, if they get fair market value for the property (asset). If they do not get fair market value for the asset, the family will get a period of ineligibility. The period of ineligibility is figured by subtracting the amount received from the fair market value of the asset and then dividing that amount by the need standard for the family. The amount is rounded down to the next lower whole number.

Cal-Learn

Cal-Learn helps pregnant and/or parenting teens under the age of 20, who are getting cash aid and do not have a high school diploma or its equivalent to stay in or return to school. Teens in the Cal-Learn Program may get cash bonuses for good grades and graduation from high school. Cal-Learn teens may get help with child care, transportation, and other services. Cash penalties may be subtracted from their family's cash aid payment for not going to school or for getting poor grades.

FOOD STAMP ONLY Utility Allowances

You will be allowed a Standard Utility Allowance (SUA) deduction if you have heating and cooling costs. If you have utility costs other than heating or cooling, such as water, sewer and garbage, you will be given a Limited Utility Allowance (LUA) deduction. If you only have a telephone cost, you will be given a Telephone Utility Allowance (TUA) deduction. The SUA, LUA and TUA are used to reduce your income, which helps you get more benefits.

MEDI-CAL/34-COUNTY CMSP ONLY Spending Down Excess Property

- If you get or apply for Medi-Cal/34-County CMSP Only and you have more property than the rules allow, you may lower it by the last day of any month, including the month of application. For Medi-Cal you may spend your excess property in any manner you want. But you may not be eligible for nursing facility level of care for a period of time if you sell or give away any property for less than its worth, and you apply for or receive Medi-Cal nursing facility level of care within 30 months of the transfer.
- You may not be eligible for 34-County CMSP if you sell or give away any property for less than it is worth.

Resources And Property

- All Medi-Cal benefits received after age 55 are subject to recovery from a deceased Medi-Cal recipient's estate. However, recovery may not exceed the value of the estate. Recovery may not occur if the beneficiary is survived by a spouse. The state may not claim the proportionate share of an estate left to a minor child or a totally disabled adult child. In addition if recovery would cause an undue hardship for any other heirs and that hardship can be demonstrated, recovery may be waived in full or in part.
- If you are institutionalized and your home or former home is not exempt, the State may record a lien against your property to repay the cost of medical care covered by Medi-Cal.

AVAILABLE SERVICES

Women, Infants and Children (WIC) Supplemental Nutrition

Program: The WIC Program is only for pregnant and breast feeding women, infants and children under age 5, who are at medical-nutritional risk. For more facts about WIC, call your local county health department or the phone number for "WIC" in the telephone book.

Voter Registration: If you want to register to vote, ask your worker to send you a registration form. If you need help filling it out, ask your worker. You can mail the form yourself. Your eligibility for aid will not be affected whether or not you register. Your worker will not tell you how to vote.

PENALTY WARNINGS

If on purpose you don't report all facts or give wrong facts to get or keep getting benefits, you can be legally prosecuted, and can be charged with committing a felony if more than \$400 is wrongly paid out for cash aid, food stamps, or Medi-Cal because you did not report all of your facts or changes in income, property, or family status. And you can be disqualified from getting cash aid or food stamps.

Disqualification Penalties

Cash Aid and Food Stamps

Disqualification penalties start after a state hearing or court of law finds that the individual has committed an Intentional Program Violation (IPV). Also, anyone who is accused of committing an IPV may agree to be disqualified by signing an Administrative Disqualification Consent Agreement or an Disqualification Hearing Waiver. Anyone who signs one of these documents gives up any hearing rights and accepts responsibility to repay any cash aid overpayment and/or food stamp overissuance.

Cash Aid Penalties

If you do not follow cash aid rules, you may be fined up to \$10,000 and/or sent to jail/prison for 5 years.

And if you are found guilty by court of law or an administrative hearing of committing certain types of fraud, your cash aid can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.

Food Stamp Only

If your household receives food stamp benefits, it must follow these rules:

- Don't give wrong or incomplete facts to get or keep getting food stamp benefits.
- Don't trade or sell your EBT card.
- Don't alter EBT card to get food stamp benefits you are not entitled to get.
- Don't use food stamp benefits to buy ineligible items such as alcoholic drinks or tobacco, paper, or cleaning products.
- Don't use someone else's EBT card for your household.

Food Stamps Penalties

If you do not follow food stamp rules, your benefits can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And you may be fined up to \$250,000 and/or sent to jail/prison for 20 years. If you are found guilty in any court of law or administrative hearing because:

- you traded or sold food stamp benefits for firearms, ammunition, or explosives, your food stamp benefits can be stopped forever for the first violation;
- you traded or sold food stamp benefits for controlled substance, your benefits can be stopped for 24 months for the first violation and forever for the second;
- you traded or sold food stamp benefits that were worth \$500 or more, your food stamp benefits can be stopped forever;
- you filed two or more applications for food stamp benefits at the same time and gave the county false identity or residence information, your food stamp benefits can be stopped for 10 years.

APPLICANT/RECIPIENT CERTIFICATION

- I understand my rights and responsibilities and agree to comply with my responsibilities.
- I also understand the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect my eligibility or benefit level for cash aid or food stamps, and/or my Medi-Cal/34-County CMSP share of cost.
- I certify I was given a copy of The Rights, Responsibilities, and Other Important Information (SAWS 2A QR).

- I also certify that, if I applied for or get cash aid, I got a copy of the following:

☐ Welfare to Work Informing Notice (WTW 5)

(APPLICANT/RECIPIENT'S INITIALS)

- I also certify that if I applied for Medi-Cal/34-County CMSP, I got a copy of the MC 219 /CMSP 219 and its contents were explained to me.

ELIGIBILITY WORKER'S CERTIFICATION

I certify that the applicant/recipient appears to understand:

- his/her rights and responsibilities and
- the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect his/her eligibility or benefit level for cash aid or food stamps, and/or share of cost for Medi-Cal/34-County CMSP

I also certify that the applicant/recipient was given a copy of:

- The Rights, Responsibilities, and Other Important Information (SAWS 2A QR)

- For cash aid:

☐ Welfare to Work Informing Notice (WTW 5)

- For Medi-Cal/34-County CMSP: the MC 219/CMSP 219 and that its contents were explained to him/her.

Signature (Parent or Caretaker Relative, Food Stamp Household Member or Authorized Representative, Medi-Cal/34-County CMSP Applicant/Beneficiary)

Date

Signature (Other Parent Living in the Home)

Witness, if You Signed With An "X"

Date

Eligibility Worker's Signature

Eligibility Worker's Number

Date

PENALTY WARNINGS

If on purpose you don't report all facts or give wrong facts to get or keep getting benefits, you can be legally prosecuted, and can be charged with committing a felony if more than \$400 is wrongly paid out for cash aid, food stamps, or Medi-Cal because you did not report all of your facts or changes in income, property, or family status. And you can be disqualified from getting cash aid or food stamps.

Disqualification Penalties

Cash Aid and Food Stamps

Disqualification penalties start after a state hearing or court of law finds that the individual has committed an Intentional Program Violation (IPV). Also, anyone who is accused of committing an IPV may agree to be disqualified by signing an Administrative Disqualification Consent Agreement or an Disqualification Hearing Waiver. Anyone who signs one of these documents gives up any hearing rights and accepts responsibility to repay any cash aid overpayment and/or food stamp overissuance.

Cash Aid Penalties

If you do not follow cash aid rules, you may be fined up to \$10,000 and/or sent to jail/prison for 5 years.

And if you are found guilty by court of law or an administrative hearing of committing certain types of fraud, your cash aid can be stopped for 6 months, 12 months, 2 years, 4 years, 5 years or forever.

Food Stamp Only

If your household receives food stamp benefits, it must follow these rules:

- Don't give wrong or incomplete facts to get or keep getting food stamp benefits.
- Don't trade or sell your EBT card.
- Don't alter EBT card to get food stamp benefits you are not entitled to get.
- Don't use food stamp benefits to buy ineligible items such as alcoholic drinks or tobacco, paper, or cleaning products.
- Don't use someone else's EBT card for your household.

Food Stamps Penalties

If you do not follow food stamp rules, your benefits can be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And you may be fined up to \$250,000 and/or sent to jail/prison for 20 years. If you are found guilty in any court of law or administrative hearing because:

- you traded or sold food stamp benefits for firearms, ammunition, or explosives, your food stamp benefits can be stopped forever for the first violation;
- you traded or sold food stamp benefits for controlled substance, your benefits can be stopped for 24 months for the first violation and forever for the second;
- you traded or sold food stamp benefits that were worth \$500 or more, your food stamp benefits can be stopped forever;
- you filed two or more applications for food stamp benefits at the same time and gave the county false identity or residence information, your food stamp benefits can be stopped for 10 years.

APPLICANT/RECIPIENT CERTIFICATION

- I understand my rights and responsibilities and agree to comply with my responsibilities.
- I also understand the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect my eligibility or benefit level for cash aid or food stamps, and/or my Medi-Cal/34-County CMSP share of cost.
- I certify I was given a copy of The Rights, Responsibilities, and Other Important Information (SAWS 2A QR).

- I also certify that, if I applied for or get cash aid, I got a copy of the following:

☐ Welfare to Work Informing Notice (WTW 5)

(APPLICANT/RECIPIENT'S INITIALS)

- I also certify that if I applied for Medi-Cal/34-County CMSP, I got a copy of the MC 219/CMSP 219 and its contents were explained to me.

ELIGIBILITY WORKER'S CERTIFICATION

I certify that the applicant/recipient appears to understand:

- his/her rights and responsibilities and
- the penalties for giving incomplete or wrong facts, or for failing to report facts or situations that may affect his/her eligibility or benefit level for cash aid or food stamps, and/or share of cost for Medi-Cal/34-County CMSP

I also certify that the applicant/recipient was given a copy of:

- The Rights, Responsibilities, and Other Important Information (SAWS 2A QR)

- For cash aid:

☐ Welfare to Work Informing Notice (WTW 5)

- For Medi-Cal/34-County CMSP: the MC 219/CMSP 219 and that its contents were explained to him/her.

Signature (Parent or Caretaker Relative, Food Stamp Household Member or Authorized Representative, Medi-Cal/34-County CMSP Applicant/Beneficiary)		Date
Signature (Other Parent Living in the Home)	Witness, if You Signed With An "X"	Date
Eligibility Worker's Signature	Eligibility Worker's Number	Date